THE CANADIAN NURSE

PERIODICALS R. R.

VOLUME 52 • NUMBER 10
MONTREAL

Highlight for
OCTOBER 1956

SNIVELY MEMORIAL LECTURE

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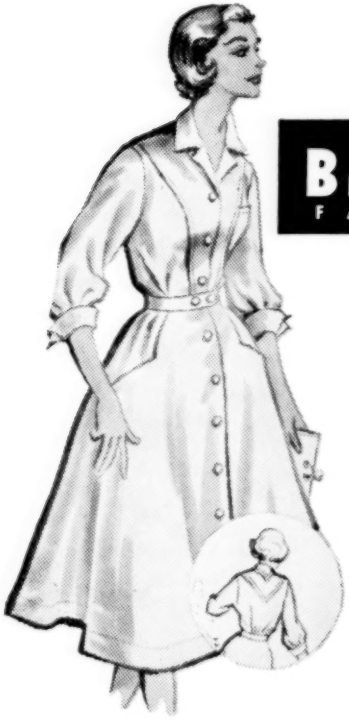

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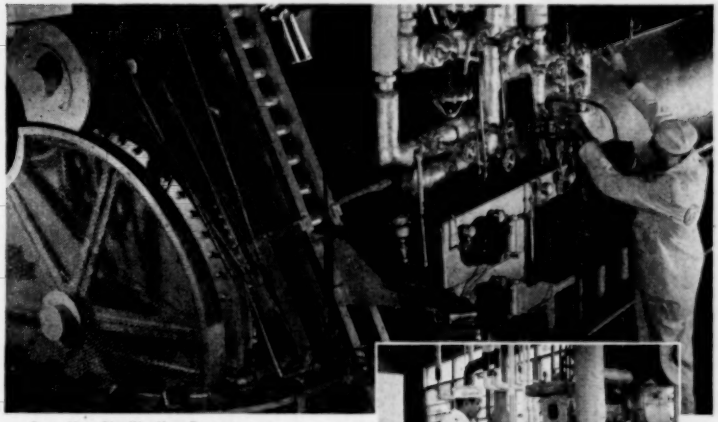

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Current Research: Carnation Evaporated Milk

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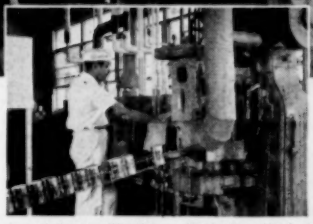
In addition to direct research, Carnation sponsors university research in highly specialized fields. A sponsored project currently under way at the Massachusetts Institute of Technology concerns the possibilities of radiation for the sterilization of evaporated milk and other dairy products.



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THE CANADIAN NURSE

L'Infirmière Canadienne

VOLUME 52 **NUMBER 10**

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Between Ourselves

OCTOBER — the month when Eastern Canada is ablaze with the glory of fall colors; when the first snow dapples the mountain peaks in Western Canada; when we pack away our summer clothes and begin to sort out warmer apparel for the winter months. In every part of our land, directors of nursing have welcomed new classes of nurses-to-be, have arranged orientation programs for new staff members, have breathed freely again as they realized their rosters were *nearly* at full strength.

At every level, too, organizational activity is reawakening after the summer lull. Student government associations have elected their new officers, staff organizations are planning for new in-service educational programs, alumnae associations and local chapters are seriously considering the most effective means of keeping the membership interested — of ensuring their presence at meetings. There are so many counter-attractions that the right key to unlock the gate to continuing active interest and participation must be sought by the executives of all these organizations. That key is in the shape of a large double "P" — Program Planning.

With such a diversity of organizations of varying age groups, in small hospitals and large, in rural as well as urban areas, with the needs of individual nurses as mixed as the groups themselves, it would be well nigh impossible to draft a master plan of programs through your *Journal*. It is possible, however, to note some of the essentials of good program planning and hope that they may be of value in any group. Some of these items may seem very elementary to experienced program committees. We hope that others who are less accustomed to preparing a program many find them useful.

1. Programs should be planned early in the organization's year and in sufficient detail that every member can be informed well in advance. An occasional "mystery" program may tantalize a few members but if good attendance is the aim, a schedule of speakers and topics should be made available to every person early in the season.

2. Use the talent in your own association. We are so prone to think that only an outside speaker will attract a worthwhile audience. Actually nurses will flock to hear the presentation of "clinics" describing new techniques and procedures. The experience of assembling their information and presenting it is valuable for everyone even the most modest and reserved nurse.

3. If an outside speaker is wanted, try to secure the top person in the particular field of interest. Remember, outstanding speakers are very human and they feel complimented to be invited to address a worthwhile organization. If they are too busy to accept, their refusal should never be regarded as an affront to the association.

4. Variety in topics may increase interest but consistency in following a general theme is of even greater value. The broad topic of Evaluation and Accreditation of Schools of Nursing is, for example, a very important consideration in association affairs. Exploring its various facets could provide interesting programs for several meetings. Discussions at the student nurses' sessions at the recent convention revealed how woefully ignorant the great majority of them were of what team nursing means. Where better can nurses learn about either of these developments than in their own organization?

5. In arranging the actual order for meetings, place the speaker early. If she is a member, possibly not too experienced in talking before a group, the suspense of sitting through a routine business session may be exhausting. If an outside speaker has been invited courtesy and consideration dictate that he should not be kept waiting until the very end of the agenda. If necessary, business can be resumed *after* the address and discussion period.

6. The person introducing the speaker should be prepared. Dignified and kindly introductions are a compliment to the speaker and to the person making the introduction. It should be brief, telling who, what, where, about the speaker and his or her work, and how or why about the topic. Avoid wise-cracks! After all, the speaker has half an hour or more to get even!

7. Thanking a speaker does not call for a re-hash of the address. Remarks should be simple and sincere, highlighting perhaps one or two memorable points that have been made. It is the chairman's privilege to thank the speaker herself or to designate a mem-

(Continued on page 776)

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New Products

Edited by DEAN F. N. HUGHES

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ALBAMYCIN CAPSULES

Manufacturer—The Upjohn Company of Canada, Toronto, Ont.

Description—Novobiocin sodium, an antibiotic derived from Streptomyces niveus.

Indications—Treatment of the most commonly occurring gram-positive and gram-negative bacterial infections particularly those caused by Staphylococcus aureus, Micrococcus aureus and Micrococcus pyogenes. Especially effective when organisms have become resistant to other antibiotics.

Administration—Orally as prescribed.

BONADOXIN

Manufacturer—Pfizer Canada, Montreal 9.

Description—Each tablet contains 25 mg. bonamine (meclizine) and 50 mg. pyridoxine hydrochloride.

Indications—For the prophylaxis and treatment of nausea and vomiting of pregnancy, motion sickness, radiation sickness, Menière's syndrome, cerebral arteriosclerosis, labyrinthine fenestration procedures and vestibular dysfunction.

Administration—Nausea and vomiting of pregnancy, initially 1 tablet at bedtime, dosage increased as indicated. Motion sickness: 1 or 2 tablets 1 hour before embarkation.

COMBISTREP

Manufacturer—Pfizer Canada, Montreal 9.

Description—Sterile dry powder containing 0.5 gm. of streptomycin and 0.5 gm. dihydrostreptomycin per gram for intramuscular use.

Indications—For tuberculous patients requiring streptomycin therapy especially in cases necessitating prolonged therapy.

Administration—For intramuscular therapy only, and must not be used intrathecally or intravenously. Dosage is the same as for streptomycin or dihydrostreptomycin.

CORDEX TABLETS

Manufacturer—The Upjohn Company of Canada, Toronto 6, Ont.

Description—Each tablet contains: Delta-1-hydrocortisone (prednisolone) 0.5 mg., 11B, 17A, 21-trihydroxy-1,4-pregnadiene-3,20-dione acetylsalicylic acid 300 mg.

Indications—Indicated in the following conditions when they are of mild to moderate severity and are not controlled by salicylates alone: rheumatoid arthritis, osteoarthritis, gouty arthritis, bursitis, tenosynovitis, myositis, fibrositis, and neuritis.

Administration—Usual dosage is 1 to 2 tablets four times daily, with a maximum dosage of 3 tablets 4 times daily. For optimal benefit, particularly in patients likely to require long-term treatment, the starting dose should be based on the patient's tolerance to acetylsalicylic acid. The initial dose should be continued until a satisfactory clinical response is obtained, at which time the dose should be reduced to a minimal effective level. To minimize the possibility of gastric irritation, each dose should be taken immediately after meals and at bedtime.

DITHRITOL

Manufacturer—Paul Maney Laboratories Canada Limited, Hamilton, Ont.

Description—Each tablet contains:Pentaerythritol tetranitrate 10 mg., dilin (dihydroxypropyl theophylline) 100 mg.

Indications—Asthma, coronary spasm, prophylaxis and treatment of left ventricular insufficiency, cardiac dyspnea and oliguresis.

Administration—Usual dosage, 1 or 2 tablets 3 times daily.

FLEET ENEMA

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Each 100 cc. of solution contains: Sodium acid phosphate U.S.P. 16 gm., sodium phosphate U.S.P. 6 gm.

Indications—For proctoscopy and sigmoidoscopy, preoperative cleansing and postoperative use, to relieve fecal or barium impactions, for use in collection of stool specimens, and as a routine enema.

Administration—Lubricate tip of the plastic rectal tube with lubricant supplied. Preferred position: Lying on left side with knees flexed, or in the knee-chest position. Maintain position until defecation impulse is felt, usually within 1 to 5 minutes. May be used at room temperature. Adults: 4 ozs. Children over 6 years: 2 ozs. Younger children: in proportion.

The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

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The Hospital for Mental Diseases, Brandon, Manitoba, offers a 6-month Diploma Course in Psychiatric Nursing to Registered Nurses.

Applicants accepted in September of each year. Salary while taking course: $205 per mo. less $25 per mo. for full maintenance.

Upon completion of course nurses are eligible for positions on Permanent Staff.

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SUPT. OF NURSES, NOVA SCOTIA SANATORIUM, KENTVILLE, N.S.

IBA-CIDE CREAM

Manufacturer—Ingram & Bell Limited, Toronto, Ont.

Description—Bacterial obstetrical cream based on the incorporation of para-chlor-metaxylenol into a smooth, non-greasy, water-soluble base.

Indications—To reduce infections during obstetrical procedures. Also indicated for sterilizing the hands and gloves prior to digital examination.

Administration—Pour about one-half teaspoonful into the palm and rub the hand gently to distribute the cream evenly over the entire surface. Continue rubbing until nearly dry. Particular attention should be paid to areas under and around the fingernail.

MEDIHALER-EPI

Manufacturer—Riker Pharmaceutical Company, Limited, Toronto 8, Ont.

Description—A 0.5% solution of epinephrine containing 0.1% ascorbic acid as a preservative in an inert propellent. Alcohol 33%. Packed in a specially designed vial with a metered dose valve and for use only with a Medihaler oral adapter.

Indications—For oral inhalation with medihaler adapter for temporary relief of the spasms and wheezing of bronchial asthma.

Administration—One or 2 inhalations as may be necessary for relief.

PROTOVAB

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Each scored tablet contains protoveratrines A and B, 0.2 mg. or 0.5 mg.

Indications—Hypertension, hypertensive cardiovascular disease.

Administration—One to 2 tablets 2 to 4 times daily. To be used in conjunction with alserin.

SERPATILIN

Manufacturer—Ciba Company Limited, Montreal.

Description—A combination of the tranquillizer, serpasil, and the mild central nervous system stimulant, ritalin. The complementary action of the two components tends to restore and maintain emotional equilibrium. Each tablet contains: Serpasil 0.1 mg., ritalin 10 mg.

Indications—Chronic fatigue and mild depressive states, with or without anxiety, tension syndrome; lethargy, menopausal syndrome; psychoneuroses associated with depression; and withdrawn, apathetic behavior. Effective in patients who complain of chronic nervous exhaustion, inability to think clearly, listlessness, apathy, lessened capacity for work or lack of energy, vague somatic disorders, preoccupation with self, pessimistic thoughts, anxiety, confusion, forgetfulness, frustration, hostility and irritability. In senile patients, lessens confusion or disorientation and improves behavior patterns.

Administration—The average dose is 1 tablet 2 or 3 times a day.

In some patients the effect of serpasil in the combination may not be immediately apparent and therapy should be continued for several days in order to obtain the full benefit.

SUVREN

Manufacturer—Ayerst, McKenna & Harrison Ltd., Montreal.

Description—Each coated tablet contains 50 mg. captodiamin (p-butylmercapto-benzyhydryl-B-dimethylaminoethyl sulfide hydrochloride), a compound possessing tension-relaxing and spasmolytic effects.

Indications—For relaxation of nervous and emotional stress without dulling mental alertness.

Administration—One or 2 tablets 3 or 4 times daily, after meals and at bedtime.

ZYLJECTIN AMPOULES

Manufacturer—Abbott Laboratories, Ltd., Montreal.

Description—Each 5-cc. contains: Procaine base 75 mg., butesin 0.30 gm., benzyl alcohol 0.25 gm., purified peanut oil q.s.

Indications—For the prolonged symptomatic relief of painful conditions in and around the anus such as fissures and pruritis.

Administration—5 to 20 cc. as required, injected into deep subcutaneous tissues. Superficial injection may produce sloughing.

(Continued from page 772)

ber to speak on behalf of the association. It *must* be arranged beforehand — not by a furtive note slipped to the designated thanker half way through the address.

Would you be interested to have a series of brief articles in the *Journal* discussing other points in the conduct of meetings, the work of committees, simplified parliamentary procedures? If so, let us know and such a series will be developed early next year.

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for

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THE NOVA SCOTIA HOSPITAL offers to qualified Graduate Nurses a six-month certificate course in *Psychiatric Nursing.*

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For information write to

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THE CANADIAN NURSE

L'Infirmière Canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52 NUMBER 10

MONTREAL, OCTOBER, 1956

Are we Equal to our Future?

BYRNE HOPE SANDERS, C.B.E.

A FEW HOURS AGO I stood in Jasper, Alberta. It was a still evening, with that soft afterglow which is almost unbearably beautiful. As I watched, the colors deepened on mountain peaks across which cloud shadows had raced all day. One mountain, aloof, remote, white-capped, towered into the opal sky. I heard someone beside me say "That white one is Edith Cavell."

The sentence sent my mind towards this moment when I would be standing before you. It seemed exactly right that this noble mountain should bear forever the name of that gentle nurse we all revere.

It is a deep responsibility to be the medium for carrying on the memory of another great nurse; to be the 1956 speaker for the Mary Agnes Snively Memorial. It is a responsibility which has challenged my heart and mind for some weeks.

You are an inspirational audience for any speaker, in the *qualities* of your experience. You deal with the realities of life and death; with the courage and cowardice that touch us all at the most unexpected moments; with the heights of beauty to which the

(Paul Rockett)

BYRNE HOPE SANDERS

Our author presented the Mary Agnes Snively Memorial Lecture on the final evening of the 28th Biennial Convention. She is Co-director, Canadian Institute of Public Opinion.

human mind can reach through suffering . . . and with the depths of selfishness to which that same suffering can sometimes bring us.

Too, you are an inspirational audience in the *range* of your experience. Some of you are young girls just starting your professional life. Some of you are mature women with a record of brilliant achievement already behind you. Some of you, I know, come from the far, lonely outposts of our land; some from the great modern hospitals that shelter a town's population within their walls.

What can I share with you that will make this evening a fitting segment in the memorial chain of addresses that honors our great Canadian nurse, Mary Agnes Snively?

I would like to turn your minds, tonight, for a little while, away from your role as nurses, as professional women — to your role as women, as Canadian women, in particular. All week you have been thinking about your professional status, your professional problems. All week you have been sharing experiences and ideas with each other, as members of the great nursing profession.

Will you think of yourselves, for a little, just as women?

Each one of us has an image of what we would like to be. One of my favorite stories is about the Great Stone Face — you surely have read it. It tells of a small boy, Ernest, who grew up in a valley deep in a range of mountains. Outlined against the sky was a Great Stone Face with a nobility and simplicity that won the heartfelt respect of everyone in the valley. Legend had it that one day a man would come home to the valley who would be the living image of that noble head. When the boy was young, a great soldier came back to his home in the Valley; and the villagers predicted that he would be the image of the Great Stone Face. But when he came — they could see he was not. Years passed, and in time a famous poet returned to the Valley. This was the one, the people felt, who would carry the image of the noble face. But as the young man looked at him, he turned away sadly; for there was no real resemblance. And, in fullness of time the boy matured and grew to be an old man, searching always for the one who would be the Great Stone Face. When he was very old, a great Statesman came back to the Valley. "This was the one," cried the people, and hurried to see him. But Ernest turned aside, sad and old, realizing how great a contrast there was. When he died, after a lifetime in the Valley, and lay in his coffin, hands folded gently across his heart, the people came and wondered, saying "See — here — at last — here is the perfect image of the Great Stone Face!"

By searching always for the true meaning of his ideal; by thinking of its nobility, its truth and beauty, the boy came, in time, to be the expression of that ideal himself. Over us all lies the image of the great nurse whose life we honor. In each of our hearts lies the secret person-image of the woman we would like to be.

An ideal is always abstract. If you study classic Greek sculpture you will see how all detail is eliminated. Eyes are blank; faces smooth; everything subordinated to a pure beauty of abstract form. Each of us must struggle daily with an infinitude of details in our everyday life. But there are certain exercises each one of us can take to help develop that personal ideal which we would like to become.

As women, let us think of ourselves, what we are and what we may become. Let us set the image of our hope before us, as the boy in the Valley saw his ideal carved out of mountain rocks.

As Canadian women, we are half the Canadian nation. Canada is one of the few remaining nations in which the sexes are balanced, fifty-fifty. In the United Kingdom and in Europe there are far more women than men. The United States has just passed the border line of an equal division. The only trouble in Canada is that too many of the men are up in the northern wilds of the country! In many of our cities there are, right now, more women than men.

In my work with the Gallup Poll, we study constantly the five regions into which Canada is divided broadly — Maritimes; Quebec; Ontario; Prairies and British Columbia. They remind me always of the five members of a very lively family — each one different, so different that you wonder

how they can form one family but as a group united deeply in a family unit. Who among us has given any real thought to what it means to be a Canadian? As the years pass we are developing our national consciousness — and as women we are half that national consciousness. I suggest that we need to give more direct, definite thought to what our nationality means to us as individuals. Ask people to tell you "off the top of their heads" what they think of first when they think "I am a Canadian" — and you will get some strange answers. While many people will reply in terms of the Royal Family — or of the Mounties! — a great many will say things like; "The cry of a loon on a lonely lake." "The sparkle of sun on fresh snow." What is your first thought in feeling "I am a Canadian?"

As Canadian intelligences, we women have to develop our opinions on national and international matters more definitively. I used to think, during my editorial work, and my work with the Government during the war, that there was a *woman's point of view*. Research has taught me that, generally speaking, there is no such thing. Women react to ideas in much the same proportion as do men, on practically every type of question.

But there is one big difference! On many important questions one finds a far greater proportion of women than men who say "I have no opinion." It is obvious that men, in the main, have more opportunity to discuss questions of the day, than does the average housewife — but it is very evident that we women, as half the national intelligence, need to think more concretely about such issues — and to decide what our own opinions are. For it is the thinking people who guide the destinies of a nation by developing public opinions. It is the leaders who make history in a nation, a community, a profession — not the masses.

Take a little time, then, to sort out your opinions about some of the important issues of the day. But don't wear the blinkers of prejudice! Remember that everyone is right — from his own point of view! It is unwise to cling tenaciously to your own ideas without considering the other person's point of view.

I have always liked a story of Sir Wilfrid Laurier. He was preparing to present a very important bill in the House, The night before, he paced his room endlessly. His secretary appealed to him; "Sir Wilfrid, why don't you stop work and take some rest? You have all your points — they are irrefutable." Sir Wilfrid said; "That's the trouble. Until I know how they can refute my ideas, I've not completed the task."

That is so true in any type of work. By facing any critic, with the thought, "This person believes he is right in criticizing me" — you have an elasticity of mind that is extremely useful in the complicated lives we lead today. Whether you are in an administrative position, or not — exercise your mind continuously in trying to see why the person who critizes you, or your actions, feels the way he does.

As a professional woman, you belong to the most popular profession for women in Canada. When we ask people which occupation, outside of marriage, they think offers the most for a young girl to enter — nursing leads the list far above any others, such as secretarial work or teaching. When we ask the nation which profession offers the least, the small percentage who name nursing do so, because, as you will probably surmise, they feel the work is too hard.

One of your problems, if you don't mind my suggesting it, lies in the very dedicated nature of your work. It is so easy for your world of ideas and contacts to narrow to the engrossing field of nursing and medical care. I remember going to Europe once and noticing a group of teachers travelling across on the same boat. As often happens, I ran into them in several spots through the ensuing summer weeks. They travelled as a group; stayed together in the same hotels; ate at the same tables; took the same tours. What, I wondered, did they really know of the people in those lands when they kept so closely together the whole time?

I would urge you to *join other professional associations*. It is valuable to learn of women's problems in other lines of work than your own. Quite frankly, I wish more nurses would enter community or public life. Believe

me, I know how busy you are; but believe me, too, there are not enough members of your profession serving in these capacities. Your own fine nursing association is, of course, your first and most beloved tie — but do experiment a little by joining with other groups. Fight the instinct which we all have to remain within our own line of work when we are off duty. In this matter it is, in all truth, a case of the pot calling the kettle black — for there is nothing I myself like better than to be with my sisters of the Press. I find it more pleasant to "talk shop" with my confreres than to make the effort to explore other avenues of professional or organizational life. So I know just how you feel. But obviously, it is a wiser course not to become too introverted in our professional life just as it is in our personal life.

I have always liked this definition of a friend; "One who brings you another pair of eyes." As a woman, will you think seriously about the importance of *supporting other women?* Believe in women, help them, like them — as intelligences, as workers, as citizens. So often we tend to belittle our sex in ways we don't realize. I always remember Ellen Fairclough, one of four women members of the Federal House, when she came to my office one day. "Byrne," she demanded, "Will you join a crusade? When you know, or hear of a man who has been particularly brilliant — will you say, 'He thinks just like a woman!' or, 'He's got a brain like a woman!'?"

It is obviously difficult for many women to enter public life — our economic and sociological patterns being what they are. But if we cannot enter public life ourselves, let us do all in our power to encourage fine women who can do so, to take up these vitally important responsibilities.

I am not an ardent feminist. I believe that women are no better, no worse than men; no kinder; no more cruel. We are, I believe, intelligences, first of all and, as such, should work together for the mutual sharing of public responsibilities.

But, as intelligences, we must exercise our minds, just as it is necessary to exercise our muscles. If we do not use certain muscles they become ineffectual. The same principle applies to our thinking habits. Let us force ourselves, therefore, into new channels of thought; read biographies of men and women in completely different spheres of life. Look beyond our own life habits continuously. My mother used to tell us children "Live on the hills. Look out and away. Don't bother with the troubles and niggardly upsets at your feet. Look out at what you would like to become — at what you would like to do . . . and work for that steadily."

As intelligences, too, we cannot help but be aware of the spiritual values in life. I have never done any research on the subject, but I am certain that nurses, basically, would be among the most religious groups there are; not, perhaps, in outward manifestation, but in a deep inward awareness. One cannot work, as you do, with the imponderables of life without being conscious of the basic instinct for a spiritual awareness in all of us. This is, as I know you know, the secret of an inner serenity.

I have always loved the line: "The gods that we worship write their names in our faces." Look at the people one meets in a single day and see the truth of that. I think of the faces of nuns I have known, and of old priests — gentle, compassionate, peaceful; of men and women with the laugh wrinkles about their eyes and tenderness at the corners of their mouth. And I think of others, with the grim hard lines of cynicism and bitterness etched in their faces. In thinking of this, I am reminded of other lines I loved:

> No star is lost we once have seen
> We always may be what we might have been.

In discussing the image of our ideals, as Ernest thought of his Great Stone Face, as thousands of men and women have thought of the beauty of Edith Cavell's mountain, I have left out many of the ideas and words we usually associate with women. But, I do want to leave three words with you which seem to me are at the heart of any ideal image we might want to foster: intelligence, courage, sensitivity.

I find them three good words to hang onto in the rough and tumble

of life which so often finds us apparently thrown. "Here's where a little courage will do the trick," I say, mentally picking myself up, brushing myself off, and hoping that no one has noticed my tumble. Again when troubles seem to crowd, I search for sensitivity to feel out the causes behind the sense of failure, or depression. And intelligence, of course! Isn't it a comfort the way our intelligence waits, brooding and watchful, to come to our rescue when we are finished with our debauches of self-pity and sentiment?

> No star is lost we once have seen.
> We always may be what we might have been.

It's a stimulating and exciting adventure, this reality of being a Canadian woman in the midst of the twentieth century. Good luck to each of you, good luck to all of us.

SOMMES-NOUS EN MESURE DE FAIRE FACE A L'AVENIR ?

BYRNE HOPE SANDERS, C.B.E.

IL Y A QUELQUES HEURES à peine j'étais à Jasper, Alberta, où j'admirais l'incomparable paysage. C'était une soirée douce et paisible . . . les derniers reflets du soleil couchant caressaient les cimes et ce spectacle était d'une grandeur impressionnante. Sous mes yeux émerveillés les lueurs dorées commencèrent à prendre un ton plus profond et les pics, où l'ombre des nuages avait dansé tout le jour, commencèrent à s'assombrir. Bien haut dans le ciel couleur d'opale un pic majestueux se détachait, lointain, solitaire, couronné de blanc rosé par les derniers reflets. Quelqu'un près de moi murmura: "Celui-là, le blanc là-bas, c'est le Mont Edith Cavell."

Ces mots me tirèrent de ma contemplation et je pensai soudain à ce moment où je serais ici, devant vous. Il me semblait tout à fait naturel que cette noble montagne porte à jamais le nom de cette infirmière distinguée que nous révérons toutes.

C'est une grande responsabilité qui m'échoit, à moi qu'on a désignée pour évoquer la mémoire d'une autre infirmière de grande classe . . . Mary Agnes Snively. C'est une responsabilité qui a hanté mon esprit et mon coeur pendant plusieurs semaines.

Votre groupe constitue un auditoire capable d'inspirer n'importe quel conférencier . . . vu la *nature* de votre expérience. Vous qui êtes en contact avec les réalités de la vie et de la mort... avec le courage et la lâcheté qui touchent chacun de nous aux moments les plus inattendus . . . avec les sommets de la beauté que peut atteindre l'âme humaine par la voie de la souffrance . . . et avec les profondeurs de l'égoïsme où peut nous plonger cette même souffrance.

Vous êtes également un auditoire de choix vu la *variété* de votre expérience. Quelques-unes d'entre vous sont de toutes jeunes filles nouvellement lancées dans la vie professionnelle. D'autres . . . des femmes en pleine maturité avec, derrière elles déjà, un brillant passé. Et je sais que parmi vous il s'en trouve qui viennent de loin, des vastes solitudes de notre pays . . . alors que d'autres sont venues de nos grands hôpitaux modernes dont les murs abritent la population d'une ville.

Quel message puis-je vous apporter pour faire de cette soirée un anneau qui s'adapte harmonieusement à la chaine des conférences qui ont été instituées pour commémorer la mémoire de notre grande infirmière canadienne, Mary Agnes Snively?

L'auteur a donné la Conférence à la mémoire de Mary Agnes Snively, le dernier soir du 28ième Congrès biennal. Mlle Sanders est Co-directrice de l'Institut Canadien de l'Opinion Publique.

Ce soir, je voudrais détourner pour un moment vos esprits de votre rôle d'infirmières, de votre rôle de femmes professionnelles . . . pour considérer votre rôle en tant que femmes, en tant que femmes canadiennes particulièrement. Toute la semaine, vous avez été préoccupées de votre statut professionnel, de vos problèmes professionnels. Toute la semaine, vous avez échangé des idées, des expériences, en votre qualité de membres de la noble profession d'infirmières.

Voulez-vous oublier tout cela pour penser un tout petit peu à votre qualité de femmes, de *femmes* tout court?

Chacune d'entre nous se fait une image de ce qu'elle voudrait être. L'une de mes histoires préférées est celle de la Grande Figure de Pierre . . . vous l'avez certainement lue quelque part. Elle raconte l'histoire d'un petit garçon, Ernest, qui habitait dans une vallée entourée de hautes montagnes. La nature avait sculpté sur l'une de ces montagnes une Grande Figure de Pierre qui se détachait sur le ciel et dont la noblesse et la simplicité inspiraient le plus grand respect aux habitants de la vallée. La légende disait qu'un jour un homme viendrait dans la vallée qui serait l'image vivante de cette noble tête. Le petit garçon était encore tout jeune lorsqu'un grand soldat revint à son foyer dans la vallée. Les villageois avaient prédit que ce serait lui, l'image de la Grande Figure de Pierre. Mais lorsqu'il parut, ils s'aperçurent que ce n'était pas lui. Les années passèrent . . . puis un beau jour, un poète célèbre revint dans son village. "Ce sera lui, dirent les gens, qui aura les traits de la noble figure." Mais le jeune Ernest le regarda et se détourna tristement . . . car il n'y avait aucune ressemblance. Et le jeune homme parvint à l'âge mûr puis à la vieillesse . . . cherchant toujours sur les visages les traits de la Grande Figure de Pierre. Quant il fut devenu très vieux, un grand homme d'état revint à son village natal. "C'est lui," crièrent les gens et ils se précipitèrent pour l'accueillir. Mais Ernest se détourna encore en constatant combien le contraste était grand. Quand il mourut, après avoir passé toute sa vie dans la vallée, et qu'on le déposa dans sa tombe les mains croisées doucement sur sa poitrine, les gens le contemplèrent avec étonnement en murmurant: "Voyez . . . la voilà . . . enfin . . . l'image parfaite de la Grande Figure de Pierre."

A force de chercher sans cesse la véritable expression de son idéal . . . à force de se pénétrer de sa noblesse, de sa vérité et de sa beauté, le petit garçon était devenu lui-même l'expression de cet idéal.

Au-dessus de nous toutes plane l'image de cette grande infirmière dont nous honorons la mémoire. Dans le plus profond de nos coeurs est enfermé l'image secrète de la femme que nous voudrions être.

Un idéal est toujours abstrait. Si vous vous arrêtez pour étudier la sculpture grecque classique vous constaterez combien les détails sont simplifiés. Les yeux sont vides . . . les visages polis . . . tout est subordonné à la beauté pure de la forme abstraite. Chacune d'entre nous se débat chaque jour avec une infinité de détails. Mais il y a certains exercices que chacune peut faire pour développer cet idéal personnel que nous visons toutes.

En tant que femmes, pensons à nous-mêmes, à ce que nous sommes et à ce que nous pourrions devenir. Fixons dans notre esprit l'image de nos rêves comme le petit garçon dans la vallée qui voyat son idéal sculpté à même le roc de la montagne.

En tant que femmes canadiennes, nous représentons la moitié de la nation canadienne. Le Canada est l'une des dernières nations où les sexes sont équilibrés, moitié-moitié. Dans le Royaume Uni et en Europe, on compte beaucoup plus de femmes que d'hommes. Les Etats-Unis viennent tout juste de dépasser la ligne d'égalité. La seule chose dont nous avons à nous plaindre, ici, au Canada, c'est que trop de nos hommes sont dans les régions désolées du grand nord! Dans un grand nombre de nos villes, à l'heure actuelle, il y a plus de femmes que d'hommes.

Dans mon travail á l'Institut Canadien de l'Opinion Publique, nous étudions constamment les cinq grandes régions qui forment le Canada, soit les Maritimes, Québec, Ontario, les Prairies et la Colombie-Britannique. Ces régions ne font toujours penser à cinq membres d'une même famille, une famille pleine de contrastes . . . chacun avec une personnalité différente, tellement différente qu'on se demande

comment ils peuvent être de la même famille . . . mais comme groupe ils sont profondément unis et forment une cellule familiale harmonieuse. Laquelle d'entre nous s'est jamais demandé sérieusement ce que cela veut dire, être Canadienne? Au fur et à mesure que passent les années notre conscience nationale se développe . . . et comme femmes, nous sommes la moitié de cette conscience nationale. Je suis d'avis qu'il nous faut songer de façon plus concrète, plus positive, à notre nationalité et à ce qu'elle signifie pour nous en tant qu'individus. Demandez aux gens de vous dire spontanément ce qui leur vient à l'idée lorsqu'ils pensent "Je suis Canadien" . . . vous aurez des réponses bien étranges. Beaucoup de gens répondront en brodant sur la Famille Royale — ou sur la "Police Montée"! Plusieurs vous diront des choses comme ceci: "Le cri du canard sauvage sur un lac solitaire" ou encore "Le scintillement du soleil sur la neige fraiche." Et vous, qu'est-ce qui vous vient à l'esprit lorsque vous songez" Je suis Canadienne?"

Comme membres intelligents de la famille canadienne il importe que nous, les femmes, nous efforçions de développer de façon plus défine nos opinions sur les affaires nationales et internationales. Au cours de mon travail de journalisme et lors de mon stage auprès du Gouvernement pendant la guerre, je m'étais fait l'idée qu'il existait un *point de vue féminin*. Mon travail de recherche par la suite m'a appris que, de façon générale, il n'existe pas de telle chose qu'une opinion féminine. Sur presque chaque genre de question les femmes réagissent aux idées à peu près dans la même proportion que les hommes. Mais il y a tout de même une grande différence! Sur une grand nombre de questions importantes on constate qu'un pourcentage beaucoup plus considérable de femmes répondent: "Je n'ai pas d'opinion." Il est vrai que l'homme, en général, a plus d'occasions que la ménagère moyenne de discuter des problèmes du jour . . . mais il est évident que nous, les femmes, qui représentons 50 pour cent de l'intelligence de la nation, devons réfléchir de façon plus concrète à ces problèmes et nous former une opinion. N'oublions pas que ce sont les gens qui réfléchissent qui guident les destinées d'une nation en orientant l'opinion publique. Ce sont les personnalités dirigeantes qui façonnent l'histoire d'une nation, d'une communauté, d'une profession — et non pas la masse.

Alors arrêtons-nous donc un moment pour débrouiller nos opinions concernant les problèmes importants de l'heure. Mais gare aux préjugés! Souvenez-vous que chacun a raison . . . à son point de vue! Il n'est pas sage de vous accrocher obstinément à vos propres idées en négligeant de considérer le point de vue de l'autre personne.

J'ai toujours eu un faible pour une anecdote se rapportant à Sir Wilfrid Laurier. L'homme d'état travaillait à un mémoire important devant être soumis à la Chambre. La veille de la séance, il se mit à arpenter sa chambre et n'en finissait plus de marcher de long en large. Finalement son secrétaire, n'y tenant plus, le supplia: "Sir Wilfrid, pourquoi ne pas vous arrêter et prendre un peu de repos? Vous avez tous vos arguments en blanc et noir . . . il sont irréfutables." Sir Wilfrid répondit: "Je n'aurai pas fini ma tâche tant que je n'aurai pas prévu *leurs* arguments pour réfuter les miens."

Et ceci est vrai dans tous les domaines. Si vous faites face à la critique en songeant "Cette personne est convaincue qu'elle a raison en me critiquant," vous avez déjà atteint une souplesse d'esprit extrêmement utile dans la vie compliquée que nous menons de nos jours. Que vous soyez dans l'administration ou non, entrainez constamment votre esprit en essayant de comprendre les mobiles qui portent telle personne à vous critiquer ou à critiquer votre manière d'agir.

Comme femmes professionnelles, vous appartenez à la profession féminine la plus populaire au Canada. Quand nous demandons aux gens quelle occupation, en dehors du mariage, ils estiment offrir le plus d'avantages pour une jeune fille, le nursing est à la tête de toutes les autres y compris l'enseignement et le secrétariat. Quand nous sondons la population du pays pour savoir quelle occupation, à son avis, est la moins attrayante, le pourcentage minime qui se prononce pour le nursing estime — vous l'aurez sans doute deviné — que les infirmiè-

res travaillent trop fort.

L'un de vos problèmes — si vous me permettez de le signaler — réside dans la nature même de votre travail qui accapare toute votre énergie et toutes les ressources de votre coeur et de votre esprit. Il est si facile pour vous de rétrécir votre horizon en le bornant au champ d'action qui vous est propre et qui vous absorbe entièrement. Je me souviens avoir remarqué, au cours d'un voyage en Europe, un groupe d'institutrices faisant la traversée sur le même bateau. Comme il arrive souvent, je les rencontrai à plusieurs reprises sur le Continent au cours des semaines suivantes. Elles voyageaient en groupe, logeaient aux mêmes hôtels, mangeaient à la même table, faisaient les mêmes excursions. Et je me demandais: "Qu'est-ce qu'elles peuvent bien apprendre des habitants des pays qu'elles visitent en se tenant toujours ensemble comme des couventines?"

Je vous recommande de vous *joindre à d'autres associations professionnelles.* C'est un avantage précieux que de connaître les problèmes qui confrontent les femmes dans d'autres champs d'activités que le vôtre. Je vous avoue franchement que, pour ma part, je voudrais voir un plus grand nombre d'infirmières participer à la vie publique ou aux activités civiques. Je me rends compte — croyez-le bien — à quel point vous êtes occupées; d'autre part, croyez-moi lorsque je vous dis qu'il n'y a pas assez d'infirmières qui s'adonnent à ces activités. Bien entendu, votre propre association d'infirmières constitue votre principal lien et celui qui vous tient le plus à coeur, mais tentez une petite incursion dans les autres groupes. Luttez contre cet instinct que nous avons toutes de nous confiner à notre propre "espèce" en dehors des heures de travail. En toute franchise, il s'agit ici de l'attraction naturelle qui nous pousse à fréquenter nos "consoeurs" — par exemple, en ce qui me concerne, rien ne me plait davantage que de rencontrer mes camarades de la Presse. Je trouve plus agréable de "parler métier" avec mes confrères que faire un effort pour explorer d'autres domaines de la vie professionnelle ou publique. Je suis donc en mesure de vous comprendre. Mais de toute évidence, il est plus sage de ne pas être trop introvertie dans notre vie professionnelle, pas plus d'ailleurs que dans notre vie privée.

J'ai toujours apprécié cette définition d'une amie "Une personne qui vous apporte une autre paire d'yeux". Puis-je vous suggérer de réfléchir sérieusement, en votre qualité de femmes, à l'importance de *soutenir les autres femmes?* Faites confiance aux femmes, appréciez-les en tant qu'intelligences, en tant que travailleuses, en tant que citoyennes. Nous sommes si souvent portées à déprécier notre sexe sans nous en rendre compte. Je me souviendrai toujours du jour où Ellen Fairclough, l'une des quatre femmes membres du Parlement, entra dans mon bureau: "Byrne, me dit-elle, veux-tu entrer en croisade?" Quand vous connaissez ou que vous entendez parler d'un homme particulièrement brillant, direz-vous: "Il pense tout à fait comme une femme" ou bien "Il est aussi intelligent qu'une femme?"

Il est entendu que pour un grand nombre de femmes il est difficile de se lancer dans la vie publique, considérant notre statut économique et social. Mais si nous ne pouvons participer nous-mêmes activement à la vie publique, faisons tout en notre pouvoir pour encourager les femmes douées qui peuvent s'y consacrer et qui sont capables d'assumer ces responsabilités essentiellement importantes.

Je ne suis pas une féministe ardente. J'estime que les femmes ne sont ni meilleures ni pires que les hommes — ni plus humaines, ni plus cruelles. Je crois qu'avant tout nous sommes des êtres intelligents et que, comme tels, nous devrions unir nos efforts pour partager mutuellement les responsabilités publiques.

Cependant, comme êtres intelligents, il nous faut exercer nos esprits autant que nos muscles. Si nous ne nous servons pas de certains muscles ils s'atrophient. Le même principe s'applique à nos habitudes de réflexion. Faisons-nous donc violence pour explorer de nouveaux horizons—lisons des biographies d'hommes et de femmes dans des sphères d'activités complètement différentes. Portons nos regards et nos pensées au delà de nos propres routines de vie. Ma mère nous disait souvent lorsque nous étions enfants: "Restez sur les hauteurs. Regardez au loin

et plus haut. Ne vous arrêtez pas à scruter les bouleversements et les tracas qui sont à vos pieds. Visez haut et songez à ce que vous voudriez devenir . . . à ce que vous voudriez accomplir . . . et travaillez sans relâche pour y parvenir."

En tant qu'êtres intelligents on ne peut pas non plus s'empêcher d'être conscientes des valeurs spirituelles de la vie. Je n'ai jamais fait de recherches sur le sujet, mais je suis convaincue que les infirmières sont, fondamentalement, parmi les groupes dont les convictions religieuses sont le plus fermes; peut-être pas en manifestations extérieures mais dans la profondeur de leur âme. On ne peut pas être en contact avec les impondérables de la vie, comme vous l'êtes, sans avoir conscience de l'instinct qui anime chacun de nous sur le plan spirituel. Et vous le savez aussi bien que moi, c'est là le secret de la sérénité intérieure.

J'ai toujours aimé ce verset: "Le Dieu que nous adorons imprime son nom sur nos traits." Regardez les gens que vous rencontrez au cours d'une journée et constatez cette vérité. Je songe aux visages de certaines religieuses que j'ai connues et à ceux de certains vieux prêtres . . . empreints de bonté, de compassion, de sérénité. Je songe aux hommes et aux femmes dont le rire a creusé des sillons aux coins des yeux et dont la bouche souriante exprime la tendresse. Et je pense aux autres dont les traits portent l'empreinte du cynisme et de l'amertume. Ces réflexions me rappellent un autre vers que j'affectionne particulièrement:

L'étoile qu'on a vue briller
ne s'éteindra jamais
On peut toujours devenir
ce qu'on aurait pu être.

Au cours de ma dissertation sur notre idéal alors que j'ai évoqué Ernest et la Grande Figure de Pierre et que j'ai rappelé les milliers d'hommes et de femmes qui ont admiré le Mont Edith Cavell, j'ai laissé de côté un grand nombre des pensées et des mots que l'on associe d'habitude avec les femmes. Cependant, je voudrais vous laisser trois mots qui me semblent être à la base de tout idéal: intelligence, courage, sensibilité.

J'estime que ces trois mots sont tout indiqués pour nous soutenir dans les combats de la vie qui semblent parfois nous désarmer. Je me dis souvent: "C'est ici qu'il me faut du courage" et je me redresse, je me secoue, espérant que personne n'a remarqué ma défaillance. Et quand les difficultés m'étreignent de nouveau je fais appel à ma faculté de sentir pour tâcher de découvrir la cause de ce sentiment de défaite, de cette dépression qui m'enserre. Et je n'oublie pas cette faculté qu'est l'intelligence! N'est-ce pas un réconfort de sentir qu'elle est là en attente, qui médite et qui veille, prête à bondir pour nous secourir lorsque, enfin, on a fini de s'apitoyer sur soi-même et de flirter avec la sensiblerie?

L'étoile qu'on a vue briller
ne s'éteindra jamais
On peut toujours devenir
ce qu'on aurait pu être.

C'est une aventure excitante et stimulante que d'être une femme canadienne en plein vingtième siècle. Bonne chance à chacune de vous! Bonne chance à nous toutes!

The use of fiberglass may soon provide radical changes in setting fractures and making artificial limbs for amputees. One hospital has reported its use in the preparation of body casts where it was found to be lighter and stronger than plaster and gave a faster recovery. Meanwhile a man who had undergone double amputation successfully lined his artificial limbs with fiberglass matting and molded an artificial limb of the new material for a 12-year-old boy. A fiberglass body cast is estimated to be 7 pounds lighter than its plaster counterpart. It has the added advantages of being adjustable if the patient loses or gains weight; can be removed, cleaned and reapplied. The artificial limb is about 5 pounds lighter than wood. It is felt that the contours of the natural limb can be much more closely duplicated when fiberglass is used — an important factor in production of artificial limbs for women.

Signpost at Geneva

DOROTHY M. PERCY

IN AN UNGUARDED MOMENT, and when the Biennial still seemed comfortably far off, I promised to take part in the program by speaking on the sufficiently vague topic: "Trends in Health Services." I have since changed the title of my remarks to: "Signpost at Geneva." For this I offer no apology. In the circumstances it seemed imperative that a change of title and content be made.

It has been said by someone whose name I have long since forgotten, doubtless a public relations expert, that "news, like fish, should be fresh." I suspect that in one way or another many here today have already been exposed to the first repercussions of the Technical Discussions on Nursing which took place at the Ninth General Assembly of the World Health Organization in Geneva. To them what I have to say will not, therefore, in the strict sense of the word, be news.

However, I am under compulsion (self-imposed, perhaps, but nonetheless valid) to bring to the membership at large some word of the proceedings of that meeting. I take very seriously this matter of reporting back to the Canadian Nurses' Association. I am fully aware that it was due, in no small measure, to the strong representations made to my Minister by the CNA that the rare privilege was accorded me of accompanying the Canadian delegation and participating in the Technical Discussions. At this time I want to record my sincere appreciation of this generous gesture.

John Steele

DOROTHY M. PERCY

To understand the significance of the intense activity that centred around the Technical Discussions, it is necessary to give some background information.

It has been the custom at each General Assembly of W.H.O. to have what are known as "Technical Discussions," running concurrently with the General Assembly itself. Each year the topic is different. Last year when the Eighth General Assembly met in Mexico City the topic chosen was "Rural Health Units."

Two years ago "Nursing" was proposed as the topic for the Discussions of 1956. Between 1954 and 1956 an immense amount of careful detailed planning went into the preparation for the sessions.

This year, for the first time, the Technical Discussions were scheduled on days when there were no other main meetings. Partly for this reason and, partly too I like to think, because of the intrinsic interest of the subject, the opening and closing sessions of the Technical Discussions were extremely well attended by official delegates of the various countries.

This year's Technical Discussions chalked up another "first" — chairmanship by a woman. Dame Elizabeth Cockayne, Chief Nursing Officer of the Ministry of Health for England

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Miss Percy is Chief Nursing Consultant with the Department of National Health and Welfare. She was a member of the Canadian Delegation to the Ninth General Assembly of the World Health Organization held in Geneva in May, 1956.

and Wales, was nominated by the President of the Assembly for this post and appointed to it by the Executive Board of W.H.O.

The theme selected for the Technical Discussions — "Nurses — Their Education and Their Role in Health Programs" was submitted for study in 1955 to member countries of W.H.O.; to national associations of the International Council of Nurses; to the International Committee of Catholic Nurses and Medical Social Workers and to the national societies of the League of Red Cross Societies.

Reports were received by W.H.O. from 40 countries. These Reports had been skillfully compiled into one comprehensive Study Document, for use in the group sessions, by Miss Pearl McIver, Chief Nurse, U.S. Public Health Service, who had been seconded for several months to W.H.O. as special consultant to do this difficult and exacting job. Tribute was paid to Miss McIver on several occasions, and the timely announcement on the last morning of a special Public Health Nursing award to Miss McIver by the American Nurses' Association, then meeting in biennial session in Chicago, was well received.

Nurses accompanied official delegations from 21 countries this year. This in itself was significant, although perhaps not entirely satisfactory when one considers there are 88 member countries in the World Health Organization.

It is, perhaps, also of interest to note that those participating in the Technical Discussions did so as individuals and not as official representatives of their countries. This, of course, made for greater informality and freedom of expression.

The Reports sent in from the various countries were available in the W.H.O. Library. They made interesting reading. They were not at all stereotyped, and although many common problems were highlighted, the analysis of these problems and the suggested solutions showed considerable variation and individuality of approach. They revealed, too, the vastly differing levels of nursing development as between countries. Reading them, one could be forgiven a temporary mood of slight despair that at a few brief discussion sessions anything remotely resembling common ground could be reached. In this happily, I was mistaken. Incidentally, I heard it said by those whose opinion I value, that the Canadian Report was one of the best.

A final statistic or two before attempting to convey to you something of the feel of the sessions. Eleven hours were devoted to the Technical Discussions. In this time there were two plenary sessions — opening and closing — and three sessions each of nine discussion groups. Total registration was 213. Each of the discussion groups had an average attendance of 20. More than 200 persons attended each of the plenary sessions.

Not only was there careful preplanning for these sessions, but at the time of the actual discussions the whole resources of the World Health Organization (and I speak with unabashed awe in my voice when I say that) were placed at the disposal of the participants. These resources included the miracle of simultaneous translation. This service always impresses me tremendously and is, I feel, the amalgam that first brings together, then keeps together ideas which, in such a real sense, are the very stuff of life. The interpreters are very skilled at their job. The whole three weeks of each General Assembly every year must be something of an endurance contest for them, but nothing suggesting a bored, cynical or mechanical attitude to duty is permitted to come through the earphones. There, not only the actual words of each speaker but his nuances and shades of emphasis are faithfully given. "Artistic" is one word which occurs to me to describe the work of this essential group.

Another marvel at Geneva is the calibre of the clerical and stenographic staff. I don't know how the system works. I do know it is extremely efficient. By 6:30 each morning throughout the entire three weeks of the General Assembly each delegate received a complete set of minutes and reports of the preceding day's business, together with the current agenda.

With this tangible, practical support in the background, and also due, I should think, in large measure to the not inconsiderable powers of concentration exhibited by Dame Elizabeth

and Miss McIver, the Final Report of the Technical Discussions, as a whole, and the summary of proceedings in the nine groups were available on the Tuesday morning following the actual sessions of Friday and Saturday of the preceding week. Of course, the Rapporteurs did a little work, too!

So, the stage was set for the opening plenary session at 9:00 o'clock on Friday morning May 11th. It was held, not in the very large and dignified Assembly Hall with its five bronze doors, its murals, its thick blue carpeting, its almost perfect acoustics, but in another hall also large and well adapted to its purpose — ordinarily the scene of the work of the Budget and Program Committee of the Assembly.

There is no doubt that all those present felt this to be an historic occasion, marking as it did the first time that nurses, doctors and health administrators, on a world scale, had sat down together to consider some facets of the complex problems of nursing.

Dame Elizabeth Cockayne, in her opening remarks, reminded her audience on this, the eve of Florence Nightingale's birthday, that although Miss Nightingale herself wrote many thousands of words, she had little patience with words without action. Nurses are anticipating action in their plans to improve nursing service and to provide better educational facilities for professional nurses. Dame Elizabeth emphasized the need to limit the discussions to the role and the education of professional nurses because of the limited time available. Therefore, the activity of auxiliary nursing personnel would be considered only in relation to the role and responsibilities of professional nurses.

Dame Elizabeth then introduced the four symposium speakers whose papers set the theme for group discussions:

1. "An Account of the Preparations made in India for the Technical Discussions" by Miss Adranvala, Chief Nursing Superintendent, India.
2. "The Health Administrator Views the Role of the Nurse in the Health Program" by Dr. Allwood-Paredes, Director-General of Health, El Salvador.
3. "The Implications of this Role for Nursing Service and Nursing Education" by Miss Duvillard, Director, Bon Secours School of Nursing, Geneva.
4. "The Contribution of the Doctor and the Health Administrator in the Future Development of Nursing" by Professor Canaperia, Director, International Health Service, Italy.

There is a temptation, which must be resisted, to quote briefly from each of these papers. There is not time to do this and such random sampling would not do justice either to the authors or to their papers. I would hope that these papers would eventually be made available to everyone. Each has its own excellencies, and the whole session, admirably summed up by Miss McIver, served as a springboard for the discussion groups that followed immediately.

The real work of the Technical Discussions was, of course, done in the groups. Registrants had been assigned to groups on the basis of language choice to provide a fair distribution according to geographic areas and fields of work. A member of the Secretariat of W.H.O. was assigned to each group to assist the chairman and to facilitate arrangements. Each group selected its own Rapporteur and each group was free to choose any or all of the suggested questions contained in the background paper for discussion, or other problems if they so desired.

The three Canadians were kept quite busy: Dr. Roth, Deputy Minister of Health for Saskatchewan, and I were detailed as Rapporteurs for our respective groups which meant quite a lot of homework over the weekend to meet deadlines.

The Role of the Nurse in Health Programs

All the groups reviewed the functions in the background paper and there was general agreement that the role of the nurse will vary according to the availability of all types of health personnel, the particular health problems of the area, the stage of development of the health programs of the country, and the level of both general and professional educational achievement within each country. The specific functions which are performed by nurses in some countries may be inappropriate or impossible in other countries at

this time. Therefore, it appears necessary for each of the countries to analyze its own situations and to prepare specific statements which are in accord with conditions as they are at present in those countries. For example, there is a tendency in some countries for nurses to perform some of the technical functions formerly considered to be medical functions. Some of the groups believed that these functions were medical responsibilities and should not be delegated to nurses. Some of the groups suggested that such assignments were what prevented nurses from *nursing* which is their first professional responsibility. In other countries where nurses have been thoroughly instructed in performing these techniques (such as intravenous injections) physicians prefer to assign those functions to nurses, and if there are enough nurses to carry both nursing and technical functions of this type, this may be a very acceptable arrangement.

However, there was general agreement that certain broad basic responsibilities should be included in the role of the nurse in every country and if not included in her current role, they could be included as goals to be attained in the near future. *Five* functions are listed as being essential responsibilities of professional nursing:

1. Giving skilled nursing care to the sick and disabled in accordance with the physical, emotional and spiritual needs of the patient whether that care is given in hospitals, homes, schools or industries.

2. Serving as a health teacher or counsellor to patients and families in their homes, in hospitals or sanatoria, in schools or industries. Because of her extensive and intimate contact with patients and families, the nurse usually has the confidence of the family and is in a strategic position to put scientific information into simple language which they will understand, accept and put into practice.

3. Making accurate observations of physical and emotional situations and conditions, which have a significant bearing on the health problem and communicating those observations to other members of the health team, or to other agencies having responsibility for that particular situation. Thus the nurse is a very valuable liasion between the patient and the physician, the research scientist, the sanitarian, the social worker, the school teacher or the industrial foreman.

4. Selecting, training and giving guidance to auxiliary personnel who are required to fulfil the nursing service needs of hospital or public health agency. This also involves an evaluation of the nursing needs of a particular patient and assigning personnel in accordance with the needs of that patient at a particular time.

5. Participating with other members of the team in analyzing the health needs, determining the services needed, and in planning the construction of facilities and the equipment needed to carry out those services effectively.

The Education of the Nurse

Each of the nine groups devoted considerable time to this phase of the subject. While each group approached it somewhat differently, the conclusions reached were amazingly similar.

Recruitment of students: It was agreed by all the groups that attracting a sufficient number of qualified candidates for schools of nursing and selecting the most suitable ones, is a big problem. Several suggestions were made by the various groups which may aid or influence the recruitment of student nurses:

1. The attitude of the public towards the nursing profession influences recruitment of students more than any single factor. (Physicians can and have been influential in creating a good opinion of nursing).

2. Comfortable living quarters for students which provide them with an opportunity to lead a normal life.

3. Accurate and attractive information about the activities of and the opportunities for nurses should be conveyed to parents of potential candidates, and to teachers and students in secondary and preparatory schools. Several groups expressed a need for films, other visual aids and pamphlets in the language of the country.

4. While a good general education is an important requirement, personal characteristics such as an interest in people, a desire to serve mankind, and an ability to understand and accept people are important qualities in a nursing candidate.

5. Some countries have found that those nursing schools which provide a high standard of education attract and retain more and better qualified students. Though educational requirements are

very important, one group emphasized that a beginning must be made with the available resources. It was realized that all countries might accept this standard as their aim even though it might have to be reached through successive stages of development.

6. Bursaries or stipends should be provided for those students unable to pay for their education in nursing.

Organization and administration of basic schools of nursing: All the groups agreed that the primary purpose of a school of nursing was to provide a sound education in nursing. It was recognized that some nursing schools appear to be organized primarily to provide service to the patients of a particular hospital. Student nurses do and should render nursing care to patients. However, the nursing service assignments of students should be based on the educational needs of the student rather than on the needs of the hospital. Therefore, the majority of the groups advocated that schools of nursing be administered as separate entities and, where possible, as an integral part of a university or other educational institution.

The schools of nursing should be directed by a qualified nurse who is skilled in teaching and familiar with methods of educational administration. Physicians who are skilled teachers are also required. For this reason, as one delegate suggested, the establishment of a nursing school in a medical centre which supports a medical school also is desirable. Since the practical or clinical education of the nurse is fully as important as the theoretical instruction, all nurses who serve as nursing supervisors in the clinical areas need to be interested in education and skilled in teaching. It was agreed by all that the nurse teacher must be a competent nurse who has had post-basic preparation in teaching.

A good nursing school, as any other type of professional school, requires financial support in addition to the tuition or fees paid by students. A nursing school should not be expected to operate on funds contributed by the hospital in payment for student services. Financial support from the government or from private sources should be provided for nursing schools in the same manner as it is provided for other types of professional schools.

The budget should be adequate to provide the necessary library facilities, textbooks, teaching and laboratory equipment as well as salaries for the teaching and administrative staff. Scholarships, bursaries or stipends may be required for those students who need financial assistance. Funds for the construction and maintenance of residence halls for both students and teaching staff should be provided unless other provisions are made for the necessary living and recreational facilities.

The curriculum of the school of nursing should provide for a general education in nursing, including instruction and experience in surgical, medical, pediatric and maternity nursing. In addition, all the groups urged that more emphasis be given to preventive medicine and the promotion of health. It was agreed that experience in health centres and homes (under the supervision of public health nurses) should be included also. Recognition of the need for such background subjects as sociology and psychology was emphasized as was the need to teach and practice sound principles of mental hygiene and human relationships throughout the entire curriculum. Guidance and character building activities should be encouraged to assure the development of emotionally secure and socially acceptable young people. Modern methods of instruction such as seminar discussions, demonstrations and ward clinics should be employed as well as formal lectures.

It was pointed out that in some countries where midwifery training has been well established, nursing schools give little or no preparation in maternity nursing. Maternity nursing was believed to be an essential part of the nursing school curriculum, although the basic school should not be expected to prepare its graduates for midwifery practices.

One of the groups called attention to the preponderance of men among the nurses in some countries. It was agreed that men nursing students should be given the same instruction and experience as that required of women students.

Post-basic education: The groups agreed that teachers, supervisors, and administrators in both hospital and public health nursing services, needed additional preparation beyond that received in the basic nursing schools. Some countries have established post-basic programs of study in these fields and also in some clinical specialities. It was agreed that it is desirable that post-basic courses should be on a university level and, where possible, under university direction.

In those countries where this type of post-basic education is not available, scholarships should be provided for study outside

the country. Even when some facilities are available within the country, selected nurses with experience and maturity will benefit greatly by study abroad. Scholarships or bursaries should be available for such study.

Even the best qualified person must be learning continually if he is to keep up-to-date with scientific discovery and progress in the health sciences. Therefore, refresher courses, seminars and conferences for supervisors and teachers need to be provided. Some of these may be held jointly with other professions represented on the health team. Others may be arranged for a specific group, such as public health nurses, hospital nursing supervisors, nursing teachers for a group from several neighboring countries on a regional basis. Funds should be provided for the support of this type of refresher work.

The Administration and Effective Utilization of Nursing Services

While the background paper considered "utilization" and "administration" as separate subjects, the group chairman and rapporteurs agreed that effective utilization was one phase of good administration. Therefore, in presenting the summary of the group discussions, these two aspects were combined.

All the groups emphasized the importance of "the health team" and the value of a good team spirit. It was agreed that there are various types of teams within the hospital or public health agency. There is the administrative team made up of the medical officer and the chiefs of all divisions or departments. There are teams which may be planning and promoting a special health program such as malaria control or child hygiene. There are nursing teams on each ward or unit of a hospital or teams concerned with rehabilitation of chronic disease patients which may be composed of physician, nurse, physical therapist, occupational therapist, psychologist, etc. The hierarchy of health and hospital administration tends to make the development of the team spirit difficult — but this can be overcome by an attitude of respect for the dignity of the individual in whatever capacity he (or she) may be serving. This team spirit, which involves a mutual recognition of the responsibilities and capabilities of each member of the team, can be developed through a sharing of suitable learning experience with various members of the health professions in staff meetings, conferences and seminars and in joint participation in solving a problem which is of concern to the whole staff.

It was suggested that this interchange of knowledge about the functions of other members of the health team and experience in working as a team member should begin early — preferably while they are students in medical, nursing, or other professional schools. More emphasis on the principles of mental health, human relations, and sociology in the basic education of all members of the health team will prove beneficial, provided the faculty and other personnel of the educational institution also practise these principles of good interpersonal relationship. The medical officer is usually, though not always, the leader of a health team. Whoever is the leader must be able to inspire his teammates to work *with* him, not *for* him.

The organization of the agency administering the health services was considered briefly in several groups. Hospital or public health services are usually under the direction of a physician who is responsible for the entire health service of the agency. Even in the smallest administrative unit of the hospital or public health agency there will be one or more of several types of workers such as nurses, sanitarians, dietitians, auxiliary workers, etc. In most countries, nurses comprise the largest number of health personnel in either a hospital or a public health service.

The selection of a competent chief nurse to serve as the leader of the nursing team is considered essential. The chief nurse will be responsible to the director of the total health service for the amount and quality of nursing service required to carry out the entire health program. In this capacity (as chief of the nursing service) she would be a member of the administrative team of which the physician in charge is the team leader, and would participate on the policy level in analyzing the health service needs, in planning how best to meet those needs, and in suggesting ways by which the total service may be improved.

A similar pattern of organization on the state, provincial and national level is considered essential for effective administration. A majority of the discussion groups emphasized the need for a chief nursing officer in the national or federal health agency. This nurse should be directly responsible to the administrator of the health program for that country and some of the usual functions of such a nurse are:

1. Participating in planning the national health program;

2. Acting in an advisory capacity and as an interpreter of nursing trends to her own department and to other departments of government on matters relating to nursing;

3. Giving leadership in all areas of nursing, in particular assisting with the improvement of standards of nursing education and nursing service.

In countries where the accreditation of nursing schools and the licensing of nursing practitioners is a responsibility of the Ministry of Health, these functions would also be under the general supervision of the chief nursing officer.

The primary purpose of legislation concerning the practice of nursing is to protect the public from unqualified practitioners and ensure a high quality of nursing service. Several groups stressed that the laws should grant broad authority to the licensing body but that too many details should not be written into the law. Authority to prepare regulations regarding the details should be included but the regulations themselves should be flexible enough to permit approval of experimental types of nursing schools, granting of licences to graduates of accredited nursing schools in other countries and otherwise encourage the development of standards higher than the minimum requirements.

Several groups mentioned the importance of consulting the national nursing organization of the country before introducing any legislation. Not only will the nursing organization have many helpful suggestions to offer, but it can be a strong support in securing passage of the act.

Effective utilization of all available nursing resources is a very important aspect of good administration. Several of the groups emphasized the importance of doing job analyses to ascertain the functions of all members of the health team in order that the members understand fully not only their own functions and responsibilities but those of their co-workers. The scientific information derived from such studies will not only make it possible to plan for a better utilization of the services of each worker, but may also justify spending more money for additional equipment which, by saving nursing time, will result in more and improved services, thereby saving money in the end.

It was felt that each institution or agency should study its own problems in order to enable the nurse to work efficiently. Examples cited were: giving attention to the location of service rooms and the arrangement of equipment when the hospital or health centre is constructed; grouping patients according to the severity of their illness; providing facilities for ambulatory patients to eat their meals in a dining room instead of serving them in their ward; providing "recovery rooms" for postoperative patients so that emergency facilities and equipment may be available immediately with the minimum of time and effort.

Job analyses and studies of this type help the nurses to view their own jobs objectively and will help them to revise some of the traditional methods which have been rigidly carried out simply because that was the pattern which existed when they were students.

A careful analysis may show how the services of married nurses may be used who, because of family responsibilities, cannot engage in full-time nursing work. It may also show where men nurses can serve more effectively than they are presently permitted to do in some countries.

A point of warning was brought out by one group. Efficiency experts should be guided by a committee of physicians and nurses or they may not see the significance of certain professional details. It was also believed that the results of the studies required professional interpretation.

It is generally agreed that productive work is possible only when the workers gain personal and professional satisfaction from their employment. Assurance that their working and living enviroment offers a standard of comfort and convenience comparable to that enjoyed by other professional workers in the area is important. Therefore, administration must be concerned with the establishment of good personnel policies — hours of work, salaries, promotion policies, vacation periods, sick leave and retirement pensions. Provisions must also be made for adequate work space, the required clerical assistance and sufficient supplies and equipment to permit effective functioning.

With regard to living conditions, one of the participants said it was "essential for nurses to lead a private life, similar to that of other members of the community." This means that hospital nurses should have a choice as to living in an apartment or flat in the community or in a hostel in connection with the hospital. When the nurse prefers to live outside the hospital, her compensation should be adjusted accordingly.

In order to attract nurses to the rural

and extremely isolated areas it was suggested that comfortable houses or flats should be constructed, if none are available. Inadequate living arrangements are frequently a barrier to recruitment for remote posts. Another plan proposed called for a rotation of personnel for a two- or three-year assignment to an isolated area and then return to a more populous area for a tour of duty. The giving of scholarships to selected prospective student nurses from the remote areas, with the understanding that following their training, they will return to the area to work for a stated number of years, was also proposed.

The Final Plenary Session was of considerable interest not only for the way in which presentation of group findings was handled to save time and preserve audience interest but also for the amount of spontaneous discussion afterwards from the floor.

Mrs. Lucile Petry Leone (USA) and Sir Arcot Mudaliar (India) summarized the sessions briefly. Again, I would hope that these summaries might be made available to us. Mrs. Leone did a very skillful job, clearly and unmistakably but without oversimplification, of linking improvements in nursing education with improvement in the quality of nursing services.

The Technical Discussions were not free from constructive criticism and that is as it should be. In approved "group dynamics" fashion, participants were invited to write brief comments on the value of the discussions and to make suggestions for possible future sessions. On forms provided, participants were asked to check their professional field of work but no signatures were requested. Of the 130 replies returned, 70 were from physicians, 60 from nurses. The replies from physicians and nurses were analyzed separately. General satisfaction was expressed with the discussions.

Thirty-seven of the physicians expressed satisfaction with the method used this year and suggested that this method be used for future discussions. Thirty-two liked the opportunity given for free and informal interchange of information and views on nursing problems. Four specifically mentioned how instructive the experience had been. The physicians' most frequent criticism was the shortness of the time and the breadth of the subject to be discussed. Two replies stated that more emphasis should have been placed on the "practical" rather than on the "ideal."

In giving suggestions for future technical discussions, "earlier distribution of the documentation" was listed by 11 of the physicians. Nine suggested a more limited subject and nine recommended more time for technical discussions. Two hoped that the "next technical discussion would be as good as this one." Additional comments were made by individuals and these should be helpful to any future planning group.

The nurses were especially pleased with the background material and the preliminary discussions in the countries. Almost all commented on the value of free and informal discussion at an international level with their medical colleagues. A large number were pleased with the composition of the groups and the opportunity to meet with health personnel from such a variety of areas.

Their criticism, like those of the physicians, concerned the limited time to discuss such a comprehensive subject even though the discussions had been restricted to the education and role of the professional nurse.

Dame Elizabeth's final duty was to present the Report of the Technical Discussions at a Plenary Session of the General Assembly. As Technical Discussions are not an integral part of the Assembly there was no question of our Report being "adopted." It was, rather, *presented,* and *"notice taken of it"* (accompanied, I may tell you, by graceful tributes from the President of the Assembly, Professor Parisot of France.) Then the Report was deposited for inclusion in the official documents of the Ninth General Assembly, thus to go down into World Health Organization history.

In conclusion, I should like to share with you one or two personal impressions of the Geneva experience. I am not at all sure I can answer to your complete satisfaction or my own, these two questions:

(1) What was really accomplished?

(2) What does it all add up to for the future?

On the surface at any rate, *no new thing came out of Geneva.* Indeed there

were times when I felt: "The same old problems we've been grappling with for years: the same old clichés we've been repeating for a long, long time as we go round and round the mulberry bush looking for answers." No — perhaps there *was* nothing new, but I am not so sure but that *somewhere, sometime there may be something new because of Geneva 1956.*

To me this is the inner and ongoing significance of these Technical Discussions. I could not but feel that because of the marked degree of interest shown by doctors as well as by nurses, together with the work done before, and the follow-up which is already being planned for in some areas of the world — the stimulus engendered at Geneva might well serve as a catalytic agent in a variety of ways and in a variety of places.

Geneva 1956 might be likened to a stone dropped in a pool. I prefer the word I have used in my title — a signpost. This is a starker symbol perhaps than that of automatic, ever-widening circles — but perhaps it is more apt because it conveys the idea of responsible and deliberate choice rather than simple cause and effect. *A signpost points the way.* It serves no other purpose.

It is always a bit dangerous to assume, even for a brief moment, the prophet's mantle. Greatly daring, however, I am doing so to the extent of registering my conviction that, despite the differences in stages of development of nursing among the countries represented at the Technical Discussions (differences which made approach to a consideration of common problems sometimes difficult and at times well-nigh impossible), Geneva 1956 will be looked back upon in years to come as a signpost of no small significance.

The Nursing School Library

DOROTHY G. RIDDELL

A GOOD LIBRARY is a vital part of any school of nursing. The old, out-of-date books have been replaced by basic reference texts in the fields of medicine, surgery, obstetrics, pediatrics, psychiatry and related sciences.

There are a sufficient number of copies on the shelves. The books are easily accessible and there is evidence that they are in constant use.

School of nursing libraries would never have come into being if there had not been a budget large enough to create them and live people on committees or interested instructors who were fully conscious of the value which the continual use of a library has in the learning process.

The publisher also has assumed a responsibility for the good library for he has made the best books known through announcements, bookstalls at conventions and through contributions to such libraries. His representative, as well, not only introduces new books but stimulates a keen interest in them. When he calls at the school of nursing he takes on the role of an educational consultant, interested in a wise choice of books to meet a particular need. As a consultant, too, he must look ahead to determine what additional texts will be required to fill specific needs in an educational program.

For the representative to gain an insight into how applicable a book is, it is important that the instructor evaluate the books. Such an evaluation also provides a guide for the students as to the material to be found in the library. The instructor may always seek the help of other qualified and interested persons in preparing these reviews.

Yes, the good library owes its existence to an adequate budget, persons cognizant of the library's function and value, and students who realize that here is to be found the foundation of knowledge.

* * *

Nothing in life is more wonderful than faith — the one great moving force which we can neither weigh in the balance nor test in the crucible.

— SIR WILLIAM OSLER

Miss Riddell is Senior Inspector, Schools of Nursing, Nursing Branch, Ontario Department of Health, Toronto, Ont.

Trenna Hunter, President

IN OLDEN TIMES, astrologers were hired by notable families to make a diagram of the eastern heavens as they appeared at the time of the birth of a child and, from this diagram, to prophesy the career of the infant. Though it is highly improbable that any such horoscope was cast for Trenna Grace Hunter on the March 8th when she was born in Brandon, Man., she has made a most interesting and successful job out of living.

School teaching attracted Trenna Hunter after she had completed her senior matriculation. Following a year at Normal School she went to Alberta and for some 12 years taught in rural and urban areas, including six years at Banff. Tall, robust and active, she enjoyed and participated in all the outdoor sports for which that resort area is justly famous — skiing, skating, swimming, hiking, badminton and tennis.

The astrologists would have agreed that she was fulfilling her destiny when, in 1936, Trenna Hunter enrolled as a student nurse at the Vancouver General Hospital. Graduating with honors three years later, she won the coveted Seldon Medal for her prowess in surgical nursing. Despite this distinction, the broad field of public health nursing proved a stronger lure and she enrolled at the University of British Columbia immediately.

(Tony Archer, Vancouver)

TRENNA G. HUNTER

Armed with her certificate in public health nursing, which within a couple of years was exchanged for the degree of Bachelor of Applied Science (Nursing), Miss Hunter joined the staff of the Metropolitan Health Committee in Vancouver. Her outstanding qualities of leadership quickly ensured her promotion to the position of supervisor of affiliating students, both from the university and from local hospitals. She was also made responsible for the development of an industrial health consultant service.

The exigencies of war provided the next step in interesting experience. Miss Hunter was loaned to the B.C. Security Commission when a Japanese internment camp was opened in Vancouver in 1942. Exhibition buildings were equipped with rows upon rows of army cots, and very little else, to accommodate thousands of people. As nurse-in-charge over these unhappy evacuees, Miss Hunter was responsible for everything relating to their health and welfare. Her duties ran all the way from securing adequate supplies of soap and other toilet articles to the supervision of the construction of a 100-bed tuberculosis hospital. She used every bit of knowledge she had ever acquired about nursing, hospitals, carpentry, sewing, getting along with people and administration in this fascinating and unique job.

When, in 1944, the Metropolitan Health Committee needed a new director of nursing service, Miss Hunter's proven capabilities made her a natural choice. Under her expert guidance, the nursing service has matched the tremendous population thrust of the city in the post-war years. New divisions have been instituted, new areas embraced, new programs launched. In all of these developments Miss Hunter has been the mainspring that kept the service running smoothly.

A busy life, in truth, yet always there has been time, interest and energy for more. Since 1950, Miss Hunter has been a vice-president of the Canadian Nurses' Association. Her

election by acclamation to the presidency last June was a natural culmination to her years of leadership in our association. She will continue to lead us as she follows the destiny that impelled her to choose as the theme for this biennium, "Into the future, open a better way."

Good luck, Trenna Hunter! We are with you.

Radioactive Isotopes

V. Skerry, J. MacLean, J. Black, M. Kennedy, S. MacDonald

The following is a brief summary of the nursing care of a patient receiving treatment with radioactive isotopes. This is not a learned discussion on radioactivity but rather a description of care gained from our own experiences and the knowledge we have acquired about radiological nursing. We have divided the subject into the following headings: history and development, types and therapeutic uses, essential precautionary measures and the actual nursing care of a patient receiving gold therapy.

History and Development

We all know the story of the discovery of radium and uranium, made known more recently in the book and movie on the life of Madame Curie.

Radium owes its name to the fact that it constantly radiates energy. These radiations are due to a disintegration within the radium itself, but the process takes 1690 years even to cause it to be one-half disintegrated. These radiations come off in three types of rays: (1) *Alpha rays* — which can be stopped by a sheet of paper; (2) *Beta rays* — which go through one hundred times the thickness of a sheet of paper, or one layer of cells; (3) *Gamma rays* — which have great penetrative power and will pass through thick layers of metal. They also pass through tissues, through the body and beyond the body.

Some of these rays of radium will destroy tissue and can penetrate deeply. If they are used in particular ways, they can be made to destroy abnormal tissue, as in tumors. The release of energy is due to the expulsion of a particle from an atom which is trying to stabilize itself.

Radium is extremely expensive due to its great scarcity. The cost is $20,000 per gram, or about $600,000 per ounce, which, of course, would be a large amount of radium.

This is an old story, known to all. We are just using it as an introduction to some newer substances which are used at our hospital for the same purpose — that is, in treatment of cancerous growths or tumors. Presumably these substances will be used more widely as time goes on for diagnosis as well as treatment.

We read a great deal in the papers about the Cobalt bomb, about radioactive isotopes, and about the peacetime use of atomic energy. Much of it seems very vague and over our heads. But when we found there was something that was going on in our own hospital, we felt it was time for us to learn a little about it to be able to tell others. Some of our findings are:

It is possible to make some substances artificially radioactive, that is, capable of emitting rays of energy similar to those radium and uranium produce. This is a highly technical procedure and it will be sufficient to say that certain substances such as gold, phosphorus and iodine can be made radioactive by being bombarded with very small particles possessing terrific amounts of energy. Machines called cyclotrons were developed for projecting these bombarding particles upon targets or substances to be made radioactive.

The artificially radioactive sub-

These five students from Victoria General Hospital, Halifax, presented this topic at a session of the annual meeting of the Registered Nurses' Association of Nova Scotia last June.

stance has the same chemical properties as the stable material, but a different atomic weight. Due to the rearrangement of the neutrons in the nucleus, this isotope is now unstable and, in trying to stabilize itself, it gives off radioactivity. These substances differ from radium in that the radioactivity is usually quickly lost. In some instances it is lost in a matter of days; in some, a matter of hours or even minutes.

Since any radioactive substance takes an infinitely long period of time to completely lose its activity, the time taken to lose half its radioactivity is a more reasonable and useful property and this is known as its half-life. Some half-lives are long — Radium 1690 years; some are short — Gold 2.8 days; Iodine 8 days. At the end of the half-life, the material is only half as radioactive as it was at the beginning of the period. For instance, radioactive gold has a half-life of nearly three days, that is to say, at the end of that time it retains only half its original activity. At the end of another three days, only a quarter of its original activity and by the end of nine days only one-eighth of its original activity is retained. Thus, the material loses half its activity at the end of every half-life but it would take forever to completely lose its radioactivity.

The Beta rays of these radioactive isotopes are used in radiation therapy. These are the ones that will go through a few thicknesses of paper. More than that, they are absorbed by the tissues where they continue to lose their radioactivity.

By their very nature radioactive isotopes are potentially dangerous to patients, doctors and nurses, and should be used only by those having a sound knowledge of the physics of radiation and the biological effects of ionizing radiation on man.

Types and Uses

In considering the different types of radioactive isotopes, we shall note a few of the various types in use at present and in what conditions they have power to be most helpful in diagnosis and therapy.

Radioactive Colloidal Gold, Au 198, is used primarily for injection into the pleural or peritoneal cavities. The presence of new growths or metastases in these cavities may cause large amounts of fluid to accumulate. In the early stages, the condition may be controlled by aspiration, drugs or external radiation. However, it inevitably recurs and the patients may be miserable from the pressure of the fluid, while the actual cancerous growth causes negligible symptoms. The injection of radioactive gold, directly into the body cavity containing the fluid, may result in prolonged control of fluid production and a much more comfortable patient. The cancer is not cured, but one of its manifestations is brought under control temporarily. While this may seem to be only of relative benefit, the patient may derive a new lease on life since it allows him periods of normal activity.

Radioactive Iodine, I 131 has become of importance in thyroid cancer, hyperthyroidism and in anginal attacks. One of the most widely explored fields in isotope work in cancer is the use of radioactive iodine-tagged albumin to locate brain tumors. It has proven to be about 70 per cent accurate. This method allows the presence of a brain tumor to be determined without the need of an exploratory operation.

Radioactive Phosphorus, P 32, has become the treatment of choice for polycythemia vera. While this is not a true form of cancer, secondary complications have been known to cause death. Radioactive phosphorus, x-ray and chemicals have made it possible to control polycythemia, so that these patients have the same life expectancy as those with well treated diabetes, or pernicious anemia. P 32 is being used also in the treatment of chronic leukemia as a maintenance therapy. It has not proven to be of any value in the treatment of acute leukemia.

Radioactive isotopes can be used in shielded units as a source of radiation similar to that available from radium or a high voltage x-ray machine. The isotope which is considered here is *Cobalt 60.* It has many vastly important advantages over radium, in its quality of radiation, and the flexibility of its use.

We have considered the artificial man-made isotopes up until now, but radium is a natural radioactive isotope,

with which we are all familiar. In this hospital we use a great deal of radium in gynecology, and in cancerous growths of the face, nose, mouth and in superficial cancerous lesions. Radium remains an exceedingly useful therapeutic substance and has as yet not been completely replaced by man-made radioactive materials. With the artificial isotopes, however, diagnostic procedures and new research procedures are being developed that seemed impossible before the advent of the atomic age.

Precautionary Measures

Nurses working with radioactive isotopes frequently ask the question: "What are the dangers to me?" This is natural, for the potentially dangerous radiations emitted by radioactive isotopes can neither be seen, felt nor smelled and one may become lax about the use of proper precautions against such an obscure foe.

A device called a "film badge" is worn by every person working near radioactive elements. This is a black plastic box containing a paper covered film. The amount of blackening on the film, found after development, changes with the amount of exposure to the radiation. Usually every two weeks the film is developed and the amount of the wearer's exposure to the radiation is determined.

There are many ways a nurse may be protected from radioactive rays, such as keeping her distance from a radioactive patient unless she is actually doing something for him, by wearing rubber gloves when handling contaminated material, for example a bedpan containing radioactive urine, or by using tongs when handling radioactive materials directly.

Radioactive isotopes should not be used nor handled by persons with cuts or open wounds on the skin. Because of the dangers of ingestion there should be no smoking nor eating in the area of radioactivity.

Following the injection of colloidal gold, all linen used for the set-up, gloves, syringes, etc. found to be contaminated by using a Geiger counter, are put in the room with the patient for as many days as is necessary for the radioactivity to subside to a safe level.

The patient is allowed to use his own bathroom, as the amounts of radioactive substance excreted at any one time are not dangerous. The toilet should be flushed immediately.

These are a few of the most important precautionary measures which should be carried out when working with radioactive isotopes.

Careful research has indicated what can be regarded as a harmless dose. This amount, divided by ten, is taken as the maximum dose for a worker in one week. This is carefully recorded by the film badge.

Extensive repeated over-exposure to radiation may cause: nausea; loss of hair; blood changes; sterility; death.

The degree of radioactivity the nurse attains as she works near the patient depends on two things — first, the type and amount of isotope; second, the distance the nurse is from radioactive material in the patient. Therefore, the key to control of absorption by the nurse depends upon (a) the distance she is from the radioactive patient and (b) the amount of time spent in actual contact with him.

Gold Instillation and Nursing Care

Radioactive Colloidal Gold is used in the treatment of pleural and peritoneal effusion arising from malignancy. The therapeutic principle is the reduction of the ascitic fluid formed. The colloidal gold, when introduced into the pleural or peritoneal cavity, causes irradiation of the serous membrane; the gold becomes plastered over the surface of the cavity. For a peritoneal injection an administration of Pantapon is first given. Following this, an abdominal paracentesis is done with a special trocar and cannula. After as much fluid as possible has been removed, 100 cc. of sterile normal saline is run into the cavity followed by the colloidal gold. Three rinses of saline through the gold container are then instilled into the cavity plus the remainder of the litre of saline. The cannula is then removed and the puncture sealed.

Following this administration the patient is returned to a special room on fourth floor of our hospital, chosen because no work is carried on in the rooms adjacent to it.

For four hours the patient is postured at 15 minute intervals. These postural changes, from side to back to side, ensure diffusion of the colloidal gold throughout the cavity. For the next four hours the patient is postured at half-hour intervals.

Following this period, no specific bedside care is indicated, other than treatment of nausea and vomiting. In some cases Pyrodoxine or Gravol is used. Nutrition is an important factor and the patient must be encouraged to eat, although loss of appetite is common. A diet rich in nutritive elements is essential.

The nursing care of a patient being treated with radioactive materials must be founded on an appreciation of the patient's mental, emotional and physical needs. The importance of this understanding is heightened by the fact, that during the first 24-hour period actual nursing care must be limited to 10 minutes per hour. It is obvious that maximum use must be made of these brief periods, to care for the emotional as well as physical needs. The patient must not be allowed to feel that he is being avoided nor neglected. His sense of hope, as inevitable as that of fear, is valuable and may be strengthened by a sincere and reassuring attitude on the part of the nurse, rather than by false optimism. As in any form of treatment a complete explanation of the procedures employed and of the patient's external and internal reactions is essential. The apprehension and withdrawal of the patient may greatly undermine the ultimate success or failure of the therapy.

Public patients remain in the fourth floor room for five days; private patients may return to a single bed room after 72 hours. By this time radiation has decreased enough to minimize any risk.

Local pain at the site of injection up to 48 hours is a common symptom following colloidal gold instillation; nausea and vomiting may occur up to 72 hours, and a temperature elevation to about 100°. A neutrophilia occurs in 10-18 days and in 20-30 days there is a fall in hemoglobin.

Colloidal gold therapy is administered only to essentially fit patients. Its effectiveness in terminal stages of disease is likely to be slight.

Gold therapy was first used in this hospital in July, 1955. Its ultimate success can scarcely be realized at this point. However, with continued usage in the future, it is hoped that some relief from pain and discomfort may be obtained by patients with malignant disease.

In conclusion, radioactive isotopes do not *cure* cancer, but they relieve pain and discomfort associated with it, and help to locate malignant metastases.

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With the ancients I believe that as a man speaks, so is he. Therefore will I live aware of my world: having a listening ear, a seeing eye, an understanding heart and an expressive tongue. I will pay as much attention to my address as to my dress, for words are power. I acknowledge them to be the flowering of the mind, the message of the heart, the ambassadors of the soul. Nor will I be guilty of speaking idle words, guarding my tongue as a door unto a treasure-house wherein dwells wisdom bought with knowledge and experience, tolerance purchased by failures, compassion paid for dearly out of suffering. Therefore, if I speak at all I will speak clearly and in good taste, simply and effectively, in the correct use of our mother tongue. — *Selected*

NURSING PROFILES

Alice Girard, as first vice-president of the Canadian Nurses' Association, will lend able assistance to our national executive in guiding professional affairs. Completely bilingual, she is a graduate of St. Vincent de Paul Hospital, Sherbrooke, Que. and holds her certificate in public health nursing from the University of Toronto. In addition Miss Girard secured her B.S. degree from the Catholic University of America, Washington, D.C. In 1944 she completed studies for her Master of Arts from Columbia University.

With this background of professional preparation, she has, quite naturally, been called upon to fill responsible positions. From 1942-47 she assumed directorship of the School for Public Health Nursing, University of Montreal. Miss Girard left this position to become superintendent of the nursing services of the Metropolitan Life Insurance Company in Canada. She is now the gracious, capable director of nursing at Hôpital St. Luc, Montreal. During the past biennium, when she was second vice-president, she was also chairman of the nursing service committee.

ALICE GIRARD

Helen M. Carpenter, the new second vice-president, is no stranger to the duties inherent in membership on a national executive. A graduate of Toronto General Hospital and the University of Toronto, her interests have centred on every phase of public health nursing. Her preparation for this particular field has fitted her admirably for the active role that she has and is taking. Following eight years' service with the Victorian Order of Nurses in Hamilton and Toronto, she was awarded a T.G.H. alumnae scholarship. She went on to Columbia University receiving her B.S. degree in 1943. At the end of one year as consultant in public health nursing with the B.C. Board of Health, her ability was further recognized when she was made the recipient of a Rockefeller Fellowship. Miss Carpenter secured her M.P.H. from Johns Hopkins University in 1945.

She next assumed the dual role of lecturer at the University of Toronto School of Nursing and supervisor of the nursing service of the Department of Health of East York Township. She is presently full-time on the University faculty. Actively interested in professional affairs, she has served as chairman of the Public Health Section of the Canadian Public Health Association and held the same office with the former CNA Committee on Public Health Nursing.

(Ballard & Jarrett, Toronto)

HELEN M. CARPENTER

A Maritimer of Scots descent, **E. A. Electa MacLennan** fills the position of third vice-president. Director of the school of nursing at Dalhousie University, she has had a breadth of experience in the field of nursing that makes her a valuable member of the executive team. A graduate of the Royal Victoria Hos-

pital, Montreal, Miss MacLennan received her certificate in teaching and supervision from McGill University in 1933. At the end of two years with the Montreal branch, Victorian Order of Nurses, she joined the staff of Vancouver General Hospital as clinical instructor and junior administrator in 1935. In 1937 she rejoined the V.O.N. first as a staff nurse then as a National Office supervisor before going on to Columbia University to obtain her Master of Arts degree. Once more she returned to the Victorian Order, this time as supervisor in the Eastern Canada area. In 1946 she joined the faculty of the McGill School for Graduate Nurses as assistant director and assistant professor in public health nursing, leaving this post for her present one in 1949. This year she was elected a Fellow of the American Public Health Association.

The Canadian Nurses' Association has previously benefitted from her enthusiasm and energy when she took charge of publicity work during her tenure as assistant secretary in our National Office, 1944-46. Her canny knowledge of matters pertaining to nursing will serve us well again.

(Dodge, Halifax)

E. A. Electa MacLennan

Sister Mary Felicitas, whose unfailing interest in professional matters is a byword to her confrères, will represent sisterhoods of the Quebec region. A graduate of Providence Hospital, Moose Jaw, she later obtained her B.S. degree in nursing education from the University of Ottawa and her Master's degree from Catholic University, Washington, D.C. Prior to assuming her present duties, Sister was obstetrical supervisor in her home school and then, for a short period, assistant superintendent. As a member of the A.N.P.Q. Board of Management, the advisory committee of the former Montreal School for Nursing Aids, the Editorial Board of *The Canadian Nurse* and numerous other committees, she has given freely of her knowledge and experience.

Sister M. Felicitas

Sister Mary Frances de Sales will continue to represent the Ontario sisterhood as she has done so ably since 1952. Sister is on the teaching staff of St. Michael's Hospital, Toronto as nursing arts instructor. A graduate of St. Louis University, she holds her B.Sc. in nursing education.

In tribute to her capabilities, **Sister Helen Marie** was re-elected to represent the nursing sisterhoods of the Maritime Region. Sister is director of nursing at St. Joseph's Hospital, Saint John — a post she has held since 1948. A Maritimer by birth, she received her early education in New Brunswick before undertaking her professional training at Holy Family Hospital, Prince Albert. She secured her B.S. degree in nursing education from the University of St. Louis, Missouri. Experience as a staff nurse and supervisory duty in obstetrics, and medical and surgical nursing preceded appointment to her present position. The Committee on Institutional Nursing for N.B. and the executive of the N.B.A.R.N.

have both welcomed her contribution in discharging their responsibilities.

SISTER HELEN MARIE

Adding another duty to a busy professional life, **Sister Mary Laurentia** has been chosen to represent the nursing sisterhoods of the Western Regions. A graduate of St. Vincent de Paul Hospital, Brockville, Sister obtained a certificate in clinical supervision, specializing in obstetrical nursing, from the University of Toronto. She has had wide experience in supervisory positions in operating room, obstetrical and medical nursing fields. At different times she has been associated with St. Francis General Hospital, Smith Falls, Ont.; St. Mary's Hospital, Camrose, Alta.; Providence Hospital, Daysland, Alta.; St. Joseph's Hospital, Edmonton. At present Sister is obstetrical supervisor and clinical instructor at Providence Hospital, Moose Jaw.

A lively interest in provincial affairs has won for her the office of vice-president of the Moose Jaw Chapter, S.R.N.A., and of the local unit of the Saskatchewan Council of Catholic Nurses. She has held office in the Catholic Hospital Conference of Saskatchewan for a period of four years — first as vice-president then as president — and has served on the provincial Board of Examiners.

SISTER M. LAURENTIA

In Memoriam

Mary A. Atkinson, who graduated from the Toronto General Hospital in 1912, died suddenly in June, 1956 at Toronto. Until the last two years, Miss Atkinson had been active in nursing ever since graduation.

* * *

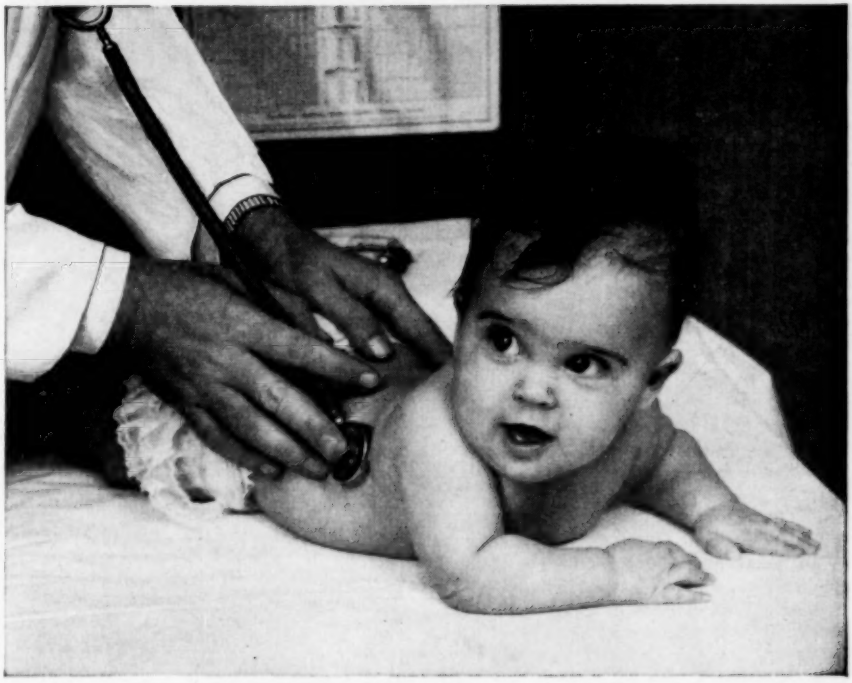
Mary Caroline Beckett, a native of Ontario who trained and worked in the United States over half a century ago, died at Phelpston, Ont., on May 16, 1956 in her 90th year.

* * *

Mary Helen Caldwell, a Nova Scotian who trained in Worcester, Mass., died at Halifax on June 13, 1956 following several months' illness. For many years Miss Caldwell engaged in district nursing in Spencer, Mass., turning to private nursing when she went back to Nova Scotia in recent years.

* * *

Lavinia Lloyd Dock, a graduate in 1886 of the Bellevue School of Nursing, New York, died on April 17, 1956 at the venerable age of 98, following a fracture of her hip. Well known to the older generation of nurses



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IN a study conducted by Leverton and Clark "Meat in the Diet of Young Infants", (J. A. M. A., *134*,1215 (1947), special prepared meat was added to the formula of full-term babies beginning at the age of six weeks and continuing for a period of eight weeks. The pediatrician in charge considered that the babies were in better physical condition generally as a result of the meat supplement. Nurses in attendance reported that the meat-fed infants seemed better satisfied, slept well and cried little.

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as co-author, with Miss Nutting, of a History of Nursing, Miss Dock's keen and penetrating mind had lost little of its vigor with advancing years. Her ability to use words with a purpose made her numerous writings masterpieces of leadership in promoting professional affairs. Through her long years as Honorary Secretary of the International Council of Nurses — from 1899 to 1924 — her enthusiasm for worldwide understanding among nurses bore fruit that, happily, she lived to see mature.

* * *

Katherine Dyck, who graduated from Saskatoon City Hospital in 1949 was one of two Canadian nurses who were drowned on August 2, 1956 when high waves dashed them off rocks near Pusan, Korea, and pulled them to sea. Miss Dyck had worked in several places in Canada before going to Korea in 1954 to serve with the Mennonite Central Committee at Ilshin Women's Hospital.

* * *

Effie Helen Forgie, who graduated from Toronto General Hospital in 1920, died at Toronto on June 3, 1956. During her 36 years in active nursing she had served as a supervisor at Fifth Avenue Hospital, New York, General Hospital, Simcoe, Ont., the Private Patients' Pavilion, Toronto General Hospital, and latterly, as superintendent of the Hillcrest Convalescent Hospital, Toronto.

* * *

Annie (Smith) Fraser, who graduated from the Royal Victoria Hospital, Montreal, in 1925, died there on August 5, 1956 following a lengthy illness. Prior to her marriage, Mrs. Fraser was head nurse on a medical ward at R.V.H.

* * *

Jean Elizabeth (Alexander) Johnson, who graduated from Toronto General Hospital in 1926, died at Hamilton on April 17, 1956.

* * *

Bertha Kornelson, a graduate of Vancouver General Hospital, was the second drowning fatality at Pusan, Korea. She was on the staff of the Pusan Children's Charity Hospital at the time.

* * *

Marie Brigitte Laliberté, who graduated from St. Jean de Dieu Hospital, Montreal, in 1927, died suddenly on August 7, 1956, at the age of 49. After two years of service in a hospital in New Jersey, Miss Laliberté joined the staff of the Montreal Department of Health, Mental Health Section. She became supervisor of this section in 1940, assistant director of nursing services in 1945 and in

BRIGITTE LALIBERTÉ

1949 was named the director of nursing services.

* * *

Lila M. Langford, chief of the collegiate nursing staff in Ottawa, died at Leamington, Ont., on July 11, 1956 after a month's illness. Before moving to Ottawa, she was with the Victorian Order of Nurses for some years serving at Waterloo and at Kirkland Lake, Ont.

* * *

Mary Carolyn (Peppler) Lippert, who graduated from the Toronto Western Hospital in 1943, was instantly killed on July 9, 1956 in an airplane accident. Prior to her marriage, Mrs. Lippert was on the staff of the Hospital for Sick Children, Toronto.

* * *

Cecelia Eileen McGuire, who graduated from New York City Hospital in 1925, died at her home in Toronto on June 29, 1956. As an instructor and the director of nursing she had served at several hospitals in New York, Wisconsin and the New England states.

* * *

Adeline Mary Page, who graduated from Toronto General Hospital in 1893, died there on July 13, 1956 at the age of 92. Miss Page had worked in many places before she retired 20 years ago.

* * *

Violet (Stevens) Paterson, who graduated from Toronto General Hospital in 1925,

(Continued on page 834)

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The Role of the Nurse in Rehabilitation

ELISABETH C. PHILLIPS, B.S., M.A.

THE CONCEPT OF REHABILITATION is wholly dependent upon the attitude of society towards it. Since the last war the attitude of many members of the patient-care team has been one of increasing consciousness of the value and needs for better rehabilitation methods. Society as a whole is also responding to the efforts of rehabilitation enthusiasts, and monies and facilities are being made more freely available.

Too many times the nurse as a member of the patient-care team has not been aware of the role that she *should* play nor have many of the other members of the team felt that the nurse's part was at all vital. To date there seems to be very little written concerning the nurse's role and only feeble efforts have been made to teach her to discharge her responsibilities well. We do not yet really know what the scope and limitations of the nurse in rehabilitation of patients can or should be and it is high time that we found out.

Perhaps some of the difficulty lies in the fact that rehabilitation and vocational placement of the handicapped have been thought to be synonymous by many. Of course, nurses are *not* prepared to help in vocational placement, but rehabilitation is *much more than placement*. Placement is, indeed, but one facet of rehabilitation and it usually comes near the end of a long chain of events. Gainful employment is of course, the goal of many rehabilitation programs, but it is far from being the *only* goal. Much needs to be done to bridge the gap between the bed and the job, and it is in these phases of rehabilitation that the nurse can become a vital team member.

Long before a handicapped person is ready for job placement, he must have mastered the rudiments of self-care. Self-care, as an important objective of rehabilitation, is justified medically, psychologically, socially and economically, as well as in a vocational sense. Dr. Howard Rusk,* has pointed out:

> Lacking specific measures in the cure of many chronic diseases, medicine must look to rehabilitation to teach those afflicted by disability to live and to work as effectively as possible with their remaining physical abilities. Until medicine finds the answer to and specific treatment of the problems in the diseases of the heart and circulation, rheumatic fever and arthritis, cerebral palsy, multiple sclerosis, poliomyelitis and the other crippling diseases, we must utilize the techniques of physical rehabilitation, psychology, social service, vocational counselling and the auxiliary specialties, to teach the disabled to live within the limits of their disability but to the full extent of their capabilities . . .
>
> Except in a few isolated instances, the physically handicapped person must be retrained to walk and travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and remove his own prosthetic appliances, and to communicate either orally or in writing. Too frequently these basic skills are overlooked. The patient is given numerous medical, psychological and vocational services in preparation for employment or self-care, but retraining

Miss Phillips is Executive Director, Visiting Nurse Service of Rochester and Monroe County, New York. This is the last of her series of papers.

*Howard A. Rusk in the Foreword to "Physical Rehabilitation for Daily Living" by Edith Buchwald — first edition, McGraw-Hill Book Company, 1952.

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in the activities of daily living is overlooked — with the result that the patient, being unable to walk and travel and care for himself, is also unable to utilize effectively the other medical, psychological, social and vocational services he has received, for richer and fuller living. Retraining in the basic activities of daily living is primary; it is simply a matter of "first things first," for daily activity skills are the basis for all subsequent activities.

The nurse has a unique opportunity, for rehabilitation *should* really start at the time of the onset of the disability or crippling condition. What other members of the patient-care team have such an early and continuing contact with the patient as do the generalized physician and nurse? The staff nurse spends a far greater number of hours at the patient's side early in the episode than does any other professional member of the team.

Do her ministrations really lead to rehabilitation? I wish I could give an unqualified "yes" to this question, but it is not so. I am not saying that the nurse does not save life or that she does not promote recovery. She does. But she could do so much more had she but the right rehabilitative viewpoint and rehabilitative know-how.

It is a fact, that her role, as she sees it, is nearly devoid of rehabilitative activities. Too often what she does for the patient actually delays rehabilitation by making him more dependent on others than his handicap justifies. We used to think the typical "good nurse" did everything for and to her patient, rather than to help him to do things for himself. She bathed him; sometimes she fed him; she picked up the newspaper he let fall to the floor; she adjusted his prosthesis for him; she took him for a ride in a wheelchair; she helped him to do this and that; she stood between him and reality; she stood between him and life as he must live it. Today, we are beginning to think that "good nursing" is something quite different.

Few situations hold more challenge for a nurse than the care of a patient who is chronically ill, yet there is no type of patient that the average nurse wants less to have the responsibility for nursing. Probably one of the reasons for this is that she feels quite insecure in caring for a long-term patient. All of her professional education has been directed to the care of the acutely ill; hence she is less certain of her relationship to the long-term patient. In many respects, large numbers of the nursing needs of chronically ill patients are the same as those of the acutely ill, but there is a whole pattern of care which is peculiar to long-term illness which needs to be understood and mastered. The progress of the patient may depend just as much on the nurse's insight into the meaning of this pattern as on the physical care she gives him.

Acute illness, is, of course, a disturbing situation for both the family and the patient, but when an illness becomes chronic or leaves a person permanently disabled, the emotional hazards and related problems are even greater. The patient's and his family's whole plan of life have been changed and probably will always have some degree of change in it. Obviously, the greatest impact of chronic illness is upon the patient himself. The loss of his capacity to function as a normal, independent, physically active, productive member of his family strikes an almost mortal blow to his personality. The problem for the nurse is to soften the effects of this blow and to help him to regain his ability to function normally insofar as it is possible for him to do so.

In order to do this the nurse must foster an atmosphere of normality about the patient to the fullest extent that his condition permits. In normal life, self-direction is a major characteristic; therefore, the nurse should consult the patient when questions arise or problems need solving regarding him personally. Nothing will frustrate him more than to have his life ordered for him when previously he has been accustomed to making his own decisions and leading an almost independent existence. Although his life is now going to be quite different from what it was before, the patient should be given an opportunity to plan as much of it as he possibly can and to participate in *all* of the decisions that affect him. To be dependent on another individual affects our personal dignity, and is a blow to our ego. The

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person with a long-term illness is essentially the same person that he was before he became ill, with the same character traits, the same likes and dislikes, the same personality, and usually the same mental capacity.

Another thing that will foster the atmosphere of normality is to see that the patient is dressed as he normally would like to be when he appears before other persons, particularly other members of his family or his friends. It takes more time, of course, to help a patient get dressed, fix her hair, put on her cosmetics, fix his tie, and so on, but the returns from this investment in time, as measured in the morale of the patient, are tremendous.

Have you ever stopped to think of the indignity of a bedpan or how important it is to a person to have a tub bath or shower in much the same way that he did prior to his disability?

The use of perfume, jewelry, good-looking pyjamas or a pretty dressing-gown, and all those other things that we feel are important to keep up our self-respect are immeasurably *more* important to the person with a long-term illness than they are to those who are not incapacitated.

If the patient is at home he may still be as removed from the life of his family as he was while he was hospitalized. One of the tragic aspects of family life is that it is so easily possible to make a member of the family feel an outsider. There are, of course, many difficulties attendant upon bringing a person with long-term illness into all aspects of family life, but wherever possible these difficulties should be overcome. Having a patient come to the table to eat with the family or participate in some of their entertaining is often possible if thought and preparation is devoted to it before asking him to do so. The well-meaning family so many times wants to wait upon the incapacitated member. In the beginning they are only too glad to do this, but as time goes on and because he is so dependent upon them, the patient begins to be a burden. Usually he is the first to realize that this is so. Chronically ill people need to have responsibilities which they are capable of discharging — responsibilities that contribute to family and community life.

A rather diligent search of current literature reveals little that serves as a delineation of the role of the nurse in the care of the long-term patient. Sometimes we see statements made indicating that practical nurses or nursing aides should be taught to give care to such patients and the implication is that their ministrations are all that are required. Sometimes it appears that the nursing care of the chronically ill resembles closely that needed by acutely ill patients. One of the most charitable descriptions of the care given such patients by a visiting nurse reads thus: "The nurse should bathe the patient, change his surgical dressing if needed, give an enema, hypodermic or intramuscular injection, if ordered, and teach the patient how to guard his health and show the family how to care for him." All this is true, but how insipid it is in its limitations! This, indeed, is a descripton of palliative nursing only, not dynamic care. The chronically ill do need dynamic, constructive and imaginative nursing. Of this I am sure!

Rehabilitation nursing is receiving more and more attention today, yet the whole idea of its practice is old. As we look back over the history of nursing we find that some of the objectives of nursing, as we know them today, were better realized in years gone by than they have been recently. Unfortunately, this is true with regard to rehabilitative emphasis. Perhaps this surprises you, but it need not. Nurses 50 years ago did not use the word "rehabilitation," but their objective was much the same as ours today. Miss Lillian Wald, the founder of the Henry Street Visiting Nurse Service in New York gave a report before the Eighth Annual Meeting of the Associated Nurses' Alumnae of the United States and Canada in 1904. She called her paper, "The Treatment of Families in which there is Illness," and this in part is what she said:

> An Italian was visited by one of the nurses. He had recently returned from Bellevue Hospital where he had been for many weeks. The family consisted of father, mother, two boys and two girls. The patient was paralyzed below the waist and had undergone several operations; he was also suffering from three large bed sores. He was lying on a hard

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cot with one sheet over him and only rags beneath. The wife sat by the window sewing knee pants. This was the only means of support for the family.

The first thought of the nurse was removal to a hospital, but upon talking with him, she found that he had been very unhappy in Bellevue Hospital and absolutely refused to return to it. The nurse then secured an air bed for him and loaned sheets, pillow cases and night clothes. She persuaded friends to provide nourishing food. The mother sewed while daylight lasted and when it became too dark to sew she washed the sheets, pillow cases and night clothes that the nurse might have clean linen the next day.

This condition continued for several weeks when the mother began to show signs of being rundown from exertion. Again the nurse pressed the hospital, the patient still refused, but at last said he would go to any hospital but the one where he had been before. As this was the only hospital that would take him in, the situation seemed hopeless. The only way in which he could have been taken to a hospital was by physical force. We felt that it was a cruel thing to insist upon his going when he begged persistently to be left at home and said his only prayer was that he might die at home with his family.

We, therefore, made arrangements for assistance to the wife in housekeeping and sewing that she might herself nurse her husband. When the nurse told the family that such arrangements had been made, the man was overcome with emotion and fainted. He lived only a few weeks but died as he wished, at home.

This paper was read in 1904 yet it shows the definite attempt on the part of the public health nurse to rehabilitate this *family* although the actual technique of rehabilitation of the paraplegic was still unknown. Of course, she did not think she was carrying out rehabilitation nursing. Had she been asked, she probably would have said that she was simply trying to get the family back on its feet.

We have gone through a period in which we lost sight of many important phases of nursing as we concentrated our attention upon the disease rather than the patient. Modern nursing is concerned with the whole patient and with his reaction to his illness. Today's nurses should no longer be satisfied to be concerned with the disease alone.

Sometimes I think that we carry out much more rehabilitation nursing than we give ourselves credit for. The nurse who teaches a patient who has had a colostomy how to carry out his normal life pattern, is certainly doing rehabilitation nursing. So is the nurse who teaches a postpartal patient the importance of correct posture and helps her to achieve it. This, too, is rehabilitation although not of such a dramatic form.

Certainly rehabilitation nursing should be part and parcel of generalized nursing care whether that care is given in a hospital or at home. It should be available to all patients, not just to a limited few. There will be some patients who will not need this specific help in its widest sense, but we must realize that almost all patients need some type of rehabilitation nursing at some point in their convalescence. One of the reasons often given against specialized rehabilitation institutions and specialized rehabilitation staffs is that an implication is made that no efforts need be made to rehabilitate all patients, by all who care for them.

The ultimate aim of rehabilitation is to restore the handicapped individual to the fullest physical, mental, social, vocational and economic usefulness of which he is capable. Rehabilitation nursing is a continuous process beginning at the onset of the illness or even before it, in the preventive nursing care which should have been available. It continues during the illness and is part of the definitive measures that are taken for arresting the disease. Then it continues into the third phase of the care which is often called rehabilitation itself.

Rehabilitation nursing calls upon all the fundamental techniques and skills that the nurse has mastered for giving general bedside care. It also is dependent upon specialized rehabilitation techniques. Unfortunately many times our schools of nursing are not in a position to teach these specialized rehabilitation techniques. Perhaps it is because too few hospitals have rehabilitation departments in which the student nurse can have experience.

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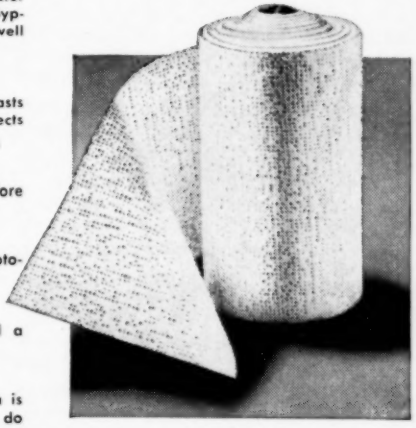

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Probably it results from a more fundamental reason. In far too many of our hospitals the emphasis is put on the care of the acutely ill rather than upon care for those who have a long-term illness. Progress *is* being made, however, in helping the young student nurse to understand preventive measures for many diseases and disabilities.

We have a long way to go to help our nurses develop rehabilitation skills. My own agency accepts undergraduate nurses from five different schools of nursing. We are continually amazed at the lack of understanding which these senior students seem to have regarding the way in which we teach patients how to use crutches. This is such a universal failing that we have now incorporated, not only the methodology of doing this, but also an hour in which the students practise walking on crutches and in so doing, learn many of the points which they must incorporate in their teaching of patients if the outcome is to be satisfactory. Fortunately some of our student nurses are learning some of the ways that braces and prostheses should be applied and used. Again, this varies materially from one school to another. Probably no school includes, in the basic curriculum, anything that prepares the nurse to participate in speech therapy for a patient who has had a cerebral vascular accident. Yet how many times might she use this knowledge to advantage while she is giving other types of care to the patient!

Teaching of self-care activities is another thing we have left out of too many of our curricula. Emphasis still seems to be on teaching the nurse how to do things *for* the patient rather than teaching the nurse *how to help patients do things for themselves.*

The greatest need for many patients is motivation. We achieve motivation by convincing the patient that he *can* regain or compensate for much of his lost power. To do this we must have a personal conviction that this is so. We must know how it can be done, how long it is likely to take and what effort must be expended in order to do it. Above all this must be done early in the course of treatment, long before the patient develops an attitude of dependence. This is not the sole responsibility of the nurse, but she *is* a key person.

Howard Rusk has stated that the true aim of rehabilitation is to train the patient to live within the limits of his disability, but to the hilt of his capacity. That capacity often surprises the patient, the physician and the nurse. Rehabilitation measures as we know them today are especially applicable to patients with polio, spinal cord injury, cerebral palsy, arthritis, speech disorders, amputation of a limb and cerebral vascular accidents. Aren't we really selling such patients "short" when we fail to include rehabilitation activities in our nursing care?

"No rational man can deny the basic physical changes which have occurred in our universe in the last hundred years. It now takes less time to girdle the earth than it took during the eighteenth century to travel from Boston to Philadelphia or from Edinburgh to London. Even if still only a small fraction of mankind uses the new means of transport, the physical interconnectedness of those who stay at home is equally a fact. The Malayan peasant's decision whether or not to hand food through the stockade to a Communist guerrilla may be determined by the opening or closing of an artificial rubber factory in the United States. The chocolate eaters in London and New York help to fix the income of cocoa farmers in the Ashanti. However violent the effort made at various times — for instance in the thirties — to insulate national economies from the forces of change or development or collapse at work in world trade, the web of commerce has grown so strongly that today the nations appear to have only two choices: either to make the intricate system function or else to strangle in its tangled skein."

The foregoing, from Barbara Ward's "Faith and Freedom," sums up the fact most of us have realized: this, for good or ill, is "one world."

A sensible girl is one who is more sensible than she looks because a sensible girl has more sense than to look sensible.

Noah was six hundred years old before he knew how to build an ark . . . don't lose your grip. — RALPH WALDO EMERSON

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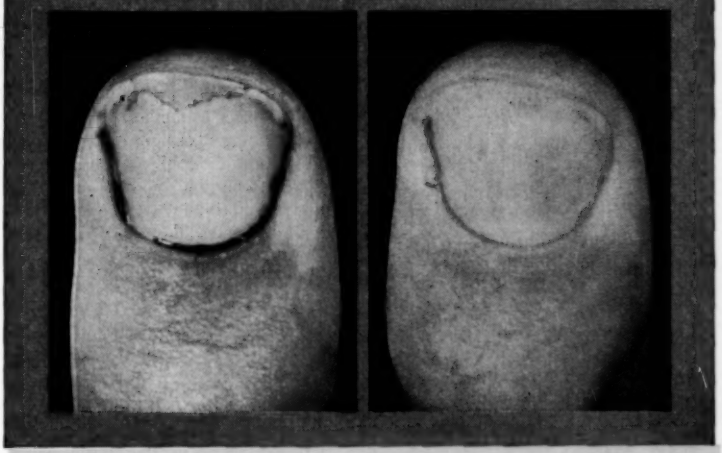

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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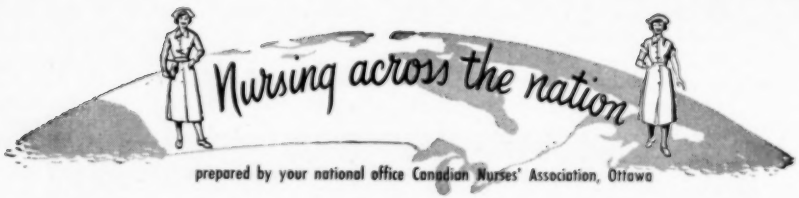

That the People be Served

In another part of this issue you will read the excellent address presented by Miss Dorothy Percy, at the 28th Biennial Meeting, entitled "Signpost at Geneva." This will bring to your mind very vividly the Technical Discussions of WHO held in Geneva last May.

We should like to quote here from the summary presented by Mrs. Lucille Petry Leone, Department of Health, Education and Welfare, at the final plenary session.

> This is the first time, on an international basis, that outstanding doctors and health administrators have met with nurses to consider together problems of nursing. This is an historic occasion; but, more important is the practical value it will have for progress in health.
>
> All who have participated in these technical discussions recognize the importance of nursing in bringing health to people and through health, raising the standard of living and freeing the human spirit for its fullest self-realization and creativity.
>
> Of all the health professions nursing is perhaps the closest to people — closest to the largest number of people.
>
> It is this closeness which calls for depth of personal understanding, tenderness, sympathy, and constructive personal and community attitudes. The people to whom we nurses are close are of all ages, from birth to old age. They have varied social and economic backgrounds. They exhibit all degrees of health from that robustness we strive to maintain, to suffering from all the scourges man is heir to which we nurses under medical direction, strive to relieve. We are close to people in their homes, in health centres, in hospitals, in the workshop; to children in schools; to people as they work together for health in community groups.
>
> Here, in this closeness, lies the justification for our learning principles of social sciences to apply in human relationships.
>
> As the definition of health is broadened and as modern science advances the responsibilities of nursing, like those of medicine and public health expand.
>
> If we speak of improving the education or training of the nurse it is for this reason; that nurses may be able, after that training, to meet their expanding responsibilities. If we say that the young men and women who want to be nurses should have reached a higher stage of education before entering training for the profession, it is because the nature of nursing requires its practitioners to be wise in many ways and its students to have foundations on which the learning of nursing can be based.
>
> If we speak of the independence of nursing education from hospital control it is because we believe that in this way nurses can be better prepared for their total responsibilities in all kinds of hospitals and in community nursing.
>
> When we speak of improved preparation of nurse teachers it is for the sake of improving the practice of nursing as it touches people.
>
> When we speak of legislation to control the practice of nursing and the licensure of various types of nursing personnel, we are speaking of protecting the public from unsafe practices.
>
> When we speak of preparing nurses for administration and placing them in administrative positions in nursing schools, hospitals, public health agencies and in national health administrations it is for the sake of improving nursing services for people.
>
> These are some of the ways in which nursing services can be improved.
>
> Population grows rapidly and the services to be rendered grow even more rapidly. And so we need more nurses everywhere.
>
> All that is done to improve nursing education will serve also to attract more

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students and make nursing a more attractive career in the minds of their parents. Stimulating teaching; variety of learning experiences inside and outside hospitals; the satisfaction of applying scientific principles in the care of people, sick and well; improving living, social, and recreational facilities for students; and the mutual respect among the members of the health professions. These will attract students. Recognition of nursing education as meriting independent support as does education for the other professions will attract discerning young people and their parents as they face career choice. So, also, will recognition of nursing as a field in which workers may advance to teaching and administrative positions increase its attractiveness.

We desire to be cooperative team members and, as our competence develops, to be members of the administrative team. We see nursing organically related to the total health effort. All our striving, even at these technical discussions, has one aim — that the people be served.

F.N.I.F. Conference

The Florence Nightingale International Foundation has announced a conference to be held on "Planning of Nursing Studies." The member countries of the International Council of Nurses are invited to send two delegates. To date, the national nurses' associations of 22 countries have indicated their wish to participate. The CNA Executive Committee has approved the attendance of Miss F. Lillian Campion, Nursing Service secretary and Miss Rita MacIsaac, assistant secretary at this conference which is to be held in Sèvres, France, November 12 to 24. 1956. Miss Margaret Arnstein, Chief, Division of Nursing Resources, Department of Health, Education and Welfare, Public Health Service, Washington, will be the conference leader.

It is anticipated that not only will the participants gain knowledge of the techniques and procedures for planning studies, but as the representatives from 22 national nurses' associations study and work together, a greater understanding of each other's problems will result.

Committees Have New Chairmen

Under the revised By-Laws of 1954, CNA national committee chairmen are appointed by the Executive Committee at the beginning of each biennium. So far those who have consented to act are Miss Alice Girard, chairman of the Committee on Finance, Miss Helen Carpenter, chairman of the Committee on Legislation and By-Laws, Miss Katherine MacLaggan, chairman of the Committee on Nursing Education and Miss Electa MacLennan, chairman of the Committee on Nursing Service.

Miss MacLaggan is new to the CNA Executive Committee but as chairman of the Committee on Nursing Education of the New Brunswick Association of Registered Nurses, was a member of the national committee from 1954-1956. New Brunswick is vitally interested in nursing education, having at present, a research study being carried out by Miss E. Kathleen Russell.

As Director, School of Nursing, Dalhousie University, Halifax, Miss MacLennan is actively engaged in the promotion of improved nursing service as indicated by the excellent institutes held yearly at that school under her direction.

We are confident that these four national committees will fulfil their functions under such capable leadership.

ICN Committe on Nursing Service

We have reported previously on the activities of the ICN Committee on Nursing Service in preparing papers on acceptance standards of various aspects of nursing service. The July issue of the *ICN Monthly Newsletter* reports that two of these papers have been made available. The paper on neurosurgical nursing, prepared in collaboration with the Swedish Nurses' Association, can be obtained in pamphlet form from the International Council of Nurses, 1, Dean Trench Street, Westminster, London S.W.1, England. The cost is one shilling plus mailing costs.

The paper on occupational health prepared in collaboration with the National Council of Nurses of Great Britain and Northern Ireland was

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published in the May issue of the *International Review*, the official organ of the International Council of Nurses.

New Publications

Health insurance is a matter which should be of concern to all nurses, both professionally and personally. Two publications have recently been received which will be helpful in understanding the issues involved: (1) The Administration of Health Insurance in Canada — by Malcolm G. Taylor, published by the Oxford University Press, Toronto, $5.00; (2) Health Insurance — a pamphlet prepared by the Canadian Welfare Council, Ottawa, $1.00.

Films on Rehabilitation

Nurses are becoming increasingly aware of the importance of rehabilitation in all aspects of nursing.

The Civilian Rehabilitation Branch of the Department of Labor, Ottawa, has prepared a list of films dealing with various aspects of rehabilitation. The films are classified according to their main content such as rehabilitation centres, welfare, crippled children, medical and surgical, etc. They are listed in two parts: (1) Those films available from Canadian organizations, local libraries and the Canadian Film Institute; and (2) films available from the United States. In addition, a short description of the film is given together with running time, producer and listing.

Schools of nursing and health agencies planning in-service educational programs will find this pamphlet very helpful. It may be obtained from Mr. Ian Campbell, National Coordinator, Civilian Rehabilitation Branch, Department of Labor, Ottawa.

Le Nursing à travers le pays

Servir le Public

Dans une autre partie de cette édition, vous pourrez lire l'excellente allocution faite par Mlle Dorothy Percy, au 28ième Congrès biennal, intitulée "Signpost at Geneva." Cela vous rappellera très clairement les délibérations techniques de l'OMS qui eurent lieu à Genève, en mai dernier.

Nous désirons rapporter ici des paroles prononcées par Mlle Lucille Petry Leone, du Ministère de la Santé et de l'Education des Etats-Unis au cours de ces assises:

"Pour la première fois, à l'échelle internationale, des médecins éminents et des administrateurs de services de santé se sont réunis pour discuter avec des infirmières des problèmes du nursing. C'est un événement historique, peut-être, mais aussi un événement qui aura une répercussion des plus heureuses sur le progrès en matière de santé.

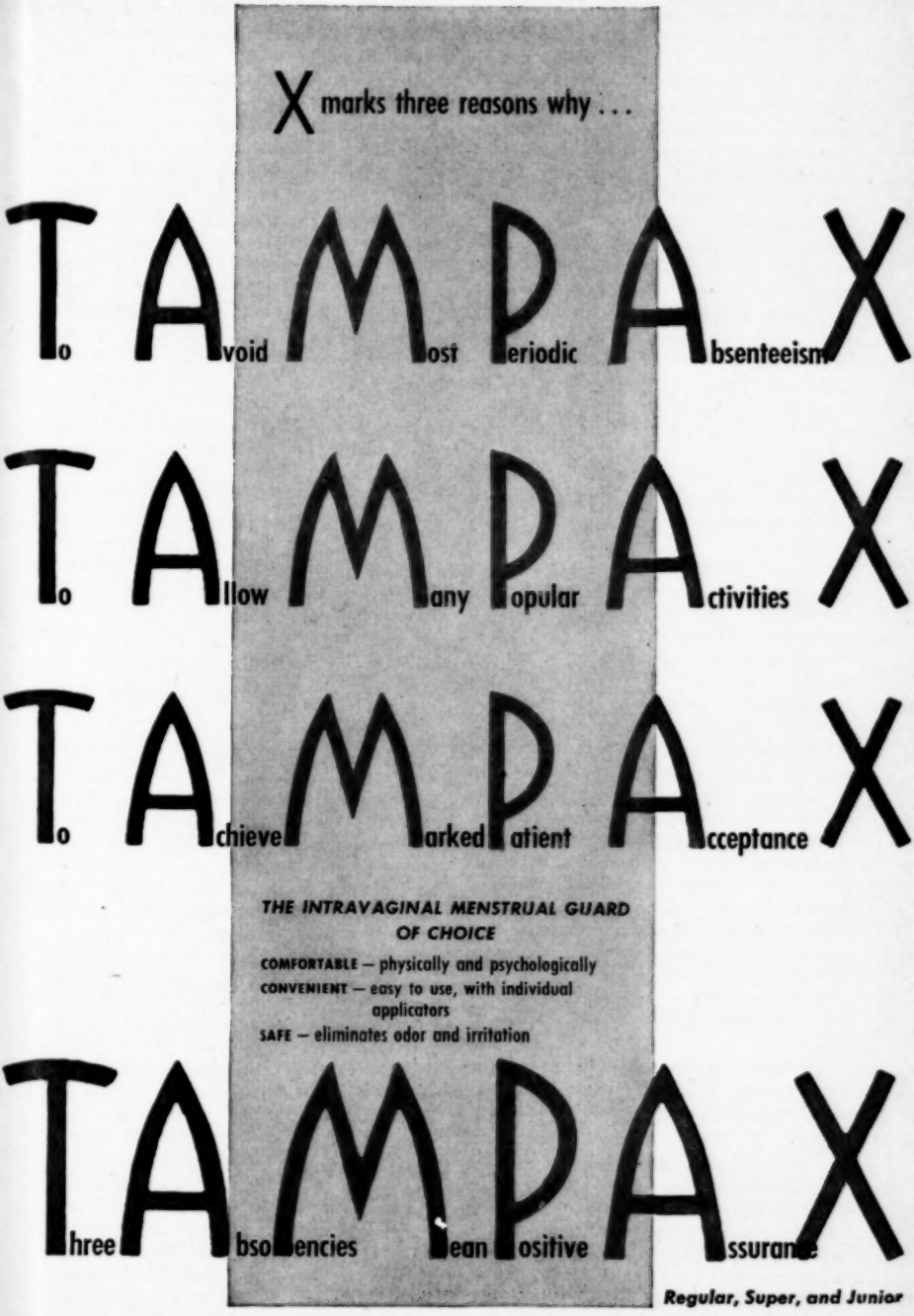
"Tous ceux qui ont pris part à ces délibérations techniques reconnaissent l'importance du nursing dans la protection de la santé publique. La santé amène une élévation du niveau de vie, libère l'esprit, favorisant ainsi la création et la réalisation des oeuvres.

"De toutes les professions ayant trait à la santé, le nursing est peut-être celle qui se penche le plus sur le peuple — elle est le plus prêt du plus grand nombre.

"Ce contact avec l'humanité demande une compréhension profonde de l'individu, de la sympathie et une attitude d'encouragement envers tous et chacun. Le peuple duquel nous nous rapprochons, nous, infirmières, comprend des personnes de tous les âges, du berceau à l'âge mûr et d'un niveau social et économique très varié. Ils possèdent la santé à divers degrés et c'est notre devoir de protéger celle des plus robustes et de venir en aide au plus faible, au moyen de conseils et d'enseignements sur la santé. Nous avons l'occasion de nous pencher sur le peuple quand nous visitons les foyers, dans nos centres d'hygiène, à l'hôpital, à l'usine, à l'école.

"L'occasion nous est constamment fournie d'appliquer dans les relations humaines les principes que nous avons eu l'avantage d'acquérir dans l'étude des sciences sociales.

"Comme le sens du mot santé s'élargit constamment et que la science fait sans cesse des progrès, les responsabilités du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nursing et de la médecine comme de l'hygiène publique sont toujours en s'accroissant.

"Pourquoi parle-t-on sans cesse d'amélioration de la formation de l'infirmière? C'est pour qu'elle soit en mesure de s'acquitter de toutes ces responsabilités. Si nous affirmons que les jeunes filles et les jeunes gens qui se destinent à la profession du nursing doivent posséder une solide éducation avant d'entrer à l'école de nursing, c'est parce que le nursing, par sa nature, exige de ceux qui le pratiquent des connaissances étendues et approfondies et par conséquent, les étudiantes en nursing doivent posséder une base solide sur laquelle sont édifiés les principes et l'art du nursing.

"Si nous parlons de l'indépendance du programme de l'enseignement du nursing du contrôle de l'hôpital, c'est parce que nous croyons que de cette façon les infirmières seraient mieux préparées pour les responsabilités multiples qu'elles devront assumer dans les différents genres d'hôpitaux et dans la collectivité.

"Lorsque nous parlons de perfectionnement dans la préparation des éducatrices en nursing, c'est dans le but unique de pouvoir prodiguer au public des soins meilleurs et un enseignement plus profitable en matière de santé.

"Lorsqu'il est question de législation pour contrôler l'exercice de la profession d'infirmière, et d'une licence ou permis d'exercer pour les différentes catégories de personnel en nursing, cela veut dire protection du public contre certaines pratiques dangereuses.

"Lorsque nous parlons de préparation d'infirmières pour occuper des fonctions administratives dans les écoles d'infirmières, les hôpitaux, les organisations d'hygiène publique et les services de santé du pays, c'est toujours dans le but d'améliorer le service du nursing dans la collectivité.

"Voilà donc des moyens qui peuvent concourir au perfectionnement du service du nursing.

"La population s'accroît rapidement et les services requis augmentent encore davantage. Partout, l'on a besoin des services de l'infirmière.

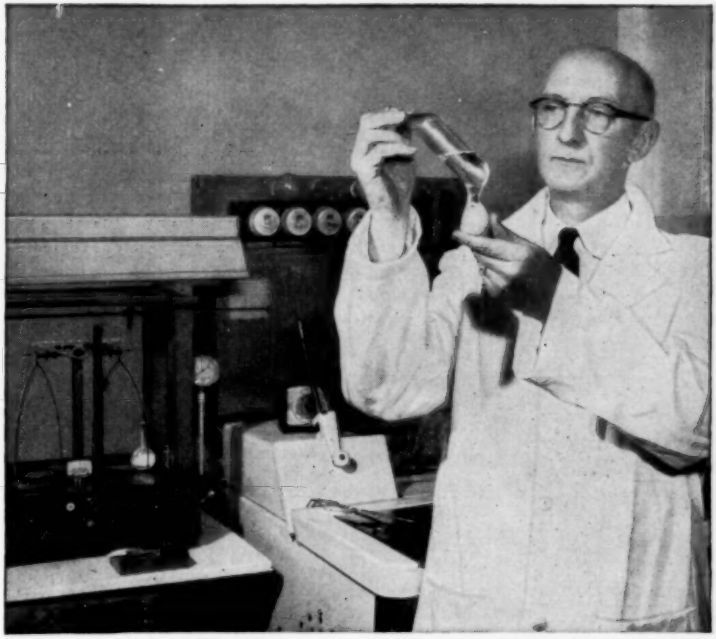
"Tout ce que l'on peut faire pour parfaire l'éducation en nursing servira aussi à attirer un plus grand nombre d'étudiants et à rendre plus attrayante la carrière d'infirmière dans l'esprit de leurs parents. Enseignement stimulant, variété de l'expérience à l'hôpital et en dehors de celui-ci, la satisfaction de pouvoir appliquer les principes scientifiques acquis, au soin des malades et à la protection de la santé des bien-portants, formes d'activité sociale susceptibles d'attirer et d'intéresser les étudiantes et le respect mutuel parmi les membres des professions. Voilà autant de facteurs qui contribueront à attirer des étudiantes à l'école d'infirmières. Lorsqu'on reconnaîtra que l'éducation en matière de nursing comme celle qui a trait à toute autre profession offre à ces éducatrices les moyens de gagner leur vie de façon très satisfaisantes, les jeunes filles éclairées et les parents avisés seront encore plus attirés vers la profession du nursing dans le choix d'une carrière. Il est donc important que la profession d'infirmière soit en mesure d'offrir un champ d'action au sein duquel les membres puissent aspirer à l'enseignement, à des fonctions administratives si l'on veut y attirer un plus grand nombre de candidates.

"Nous désirons faire partie de l'équipe du nursing et y travailler de notre mieux puis, si notre compétence nous le permet, devenir membres de l'équipe administrative. Nous envisageons le nursing organiquement lié à l'effort commun pour l'amélioration de la santé. Vers quoi tendent tous nos efforts, au cours de ces discussions d'ordre technique? Uniquement vers cet objectif: Servir le public."

Conférence de la Fondation Internationale Florence Nightingale

La Fondation Internationale Florence Nightingale a annoncé une conférence sur "Planning of Nursing Studies." Les pays membres du Conseil International des Infirmières sont invités à y envoyer deux déléguées. Jusqu'à présent, les associations nationales d'infirmières de 22 pays ont exprimé le désir de participer à cette conférence. Le Comité Exécutif de l'A.I.C. a approuvé la présence de Mlle F. Lillian Campion, secrétaire du Service du Nursing et de Mlle Rita MacIsaac, secrétaire-adjointe, à cette conférence qui aura lieu à Sèvres, France, du 12 au 24 novembre 1956. Mlle Margaret Arnstein, Chef de la Section des Ressources du Nursing de la Division de l'Education et du Bien-Etre, Ministère de la Santé de Washington, sera chargée de la direction de la conférence.

L'on se rend compte que les personnes qui auront l'avantage de prendre part à ces importantes assises n'acquéreront pas seulement des connaissances dans les techniques et procédés dans l'organisation des études mais que de plus, venant de 22 pays différents et travaillant ensemble, elles apprendront à connaître les problèmes qui se posent ailleurs ce qui, nul doute, favorisera une



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Nomination des Présidentes de Comités

Conformément aux Règlements modifiés en 1954, les présidentes des comités de l'A.I.C. sont nommées par le Comité Exécutif au début de chaque période biennale. Les personnes ayant accepté ces nominations, jusqu'à présent, sont Mlle Alice Girard, présidente du Comité des Finances, Mlle Helen Carpenter, présidente du Comité de la Loi et des Règlements, Mlle Katherine MacLaggan, présidente du Comité de l'Education en Nursing et Mlle Electa MacLennan, présidente du Comité du Service d'Infirmières.

Mlle MacLaggan est nouvelle dans l'Exécutif de l'A.I.C. mais comme présidente du Comité de l'Education en Nursing de l'Association des Infirmières enregistrées du Nouveau-Brunswick, elle fut membre du comité national de 1954 à 1956. La province du Nouveau-Brunswick est vivement intéressée dans l'éducation en nursing, poursuivant actuellement une étude de recherches sous la direction de Mlle E. Kathleen Russell.

Comme directrice de l'Ecole d'Infirmières de l'Université de Dalhousie, Halifax, Mlle MacLennan s'intéresse activement à l'amélioration du service du nursing comme en font foi les excellentes conférences organisées chaque année, sous sa direction, à cette école.

Nous sommes assurées que ces quatre comités nationaux rempliront, sous cette habile direction, leurs fonctions avec efficacité.

Comité du Service d'Infirmières du Conseil International des Infirmières

Nous avons déjà publié des articles sur les activités du Comité du Service d'Infirmières du Conseil International des Infirmières consistant dans la préparation de travaux portant sur les standards acceptables dans certains domaines du Service d'Infirmières. Le numéro de juillet du bulletin mensuel du Conseil International nous fait part que deux de ces brochures sont disponibles: l'une sur les soins en neuro-chirurgie, préparée en collaboration avec l'Association des Infirmières de Suède peut être obtenue en s'adressant au Conseil International des Infirmières, 1, Dean Trench Street, Westminster, London, S.W.1, Eng-

TANGIBLE RELIEF IN PREMENSTRUAL TENSION

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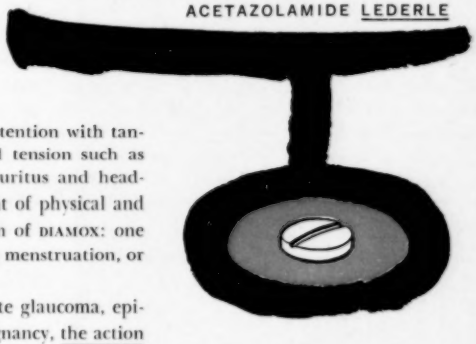

A single tablet of DIAMOX controls fluid retention with tangible relief of symptoms of premenstrual tension such as pelvic engorgement, tightness of skin, pruritus and headache. Patients report marked improvement of physical and emotional well-being on a simple regimen of DIAMOX: one tablet daily, beginning 5 to 10 days before menstruation, or at the onset of symptoms.

Of proven value in cardiac edema, acute glaucoma, epilepsy, obesity, toxemias and edema of pregnancy, the action of DIAMOX is considered a welcome departure from that of the mercurials.[1] It is well tolerated orally and even when given in large dosage side effects are rare.[2] Excretion by the kidney is complete within 24 hours with no cumulative effects.[2]

A safe, versatile drug, DIAMOX is effective not only in the mobilization of edema fluid but in the prevention of fluid accumulation as well.[2] A single dose is active for 6 to 12 hours, offering convenient daytime diuresis.

Supplied: Scored Tablets of 250 mg. (Also in ampuls of 500 mg. for parenteral use in critical cases).

1. Krantz, J. C. and Carr, C. J.: The Pharmacologic Principles of Medical Practice. Ed. 3. The Williams & Wilkins Co., Baltimore, 1954, p. 1014.

2. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2. The Macmillan Co., New York, 1955, p. 856.

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land, au prix de 1 shilling plus les frais de postes. L'autre sur la thérapie d'occupation, préparée en collaboration avec le Conseil National des Infirmières de Grande-Bretagne et de l'Irlande du Nord, fut publiée dans l'édition de mai de la *Revue Internationale*, organe officiel du Conseil International des Infirmières.

Films sur la Réhabilitation

Les infirmières se rendent de plus en plus compte de l'importance de la réhabilitation dans le nursing sous tous ses aspects.

La Section de la Réhabilitation Civile du Ministère du Travail, Ottawa, a préparé une liste de films traitant des divers aspects de la réhabilitation. Les films sont classifiés d'après le sujet dont ils traitent soit: centres de réhabilitation, bien-être, enfants infirmes, médecine et chirurgie, etc. Ils se divisent en deux catégories: (1) Les films que l'on peut obtenir d'organisations canadiennes, librairies locales et de l'Institut Canadien du Film; et (2) ceux que l'on peut se procurer aux Etats-Unis. On donne aussi une courte description de chaque film, sa durée, le nom du producteur, etc.

Les écoles d'infirmières et les organisations d'hygiène publique qui désirent établir un programme éducatif au sein de leurs institutions, trouveront ces petites brochures descriptives très utiles. On peut les obtenir en s'adressant à Mr. Ian Campbell, National Coordinator, Section de la Réhabilitation Civile, Ministère du Travail, Ottawa.

Nouvelles publications

L'assurance santé est une question qui devrait intéresser toutes les infirmières, professionnellement et personnellement. Deux brochures intéressantes ont été publiées à ce sujet: (1) The Administration of Health Insurance in Canada — par Malcolm G. Taylor, publié par Oxford University Press, Toronto, $5.00; (2) Health Insurance — brochure préparée par le Conseil Canadien du Bien-Etre, Ottawa, $1.00.

* * *

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* * *

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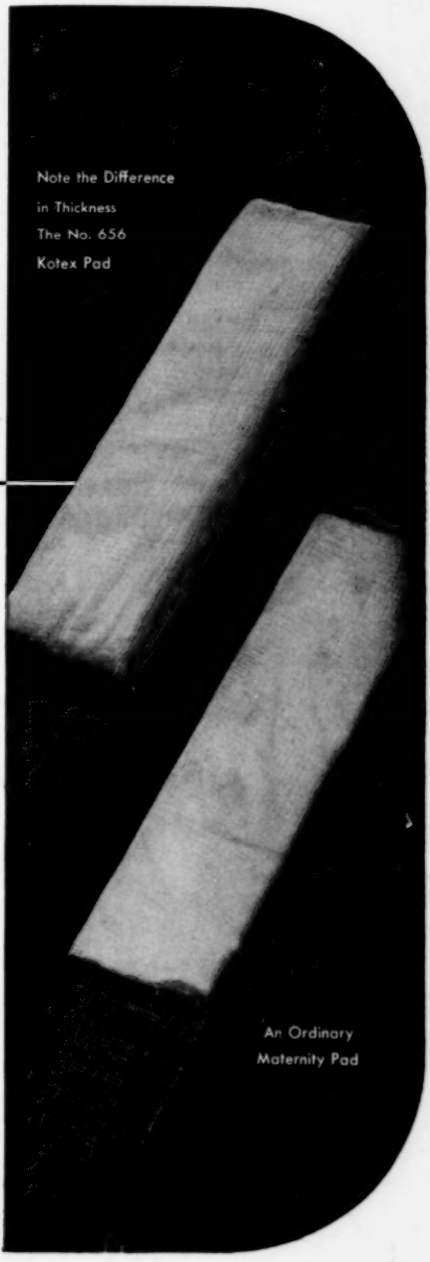
No. 656 KOTEX maternity pad



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NEW MATERNITY BELT. For most efficient operation with the No. 656 Maternity Pad, use the new Kotex Maternity Belt. Forget old-fashioned T-binders. New belt fits around waist and snaps on—*no pins!*

BIG SAVINGS! Save dressing costs and hours of nurse time. See your Curity representative for details today!

Extra Features of 12-inch No. 656 Kotex Pad

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If you are not already scheduled to receive the Journal every month, we invite the immediate fill in and return of the convenient order form below. It will bring you, in addition to 12 issues of nursing's most useful publication, a complimentary copy of the just-off-the-press 88 page "Advances in Nursing Care," a 135-report summary of needful-to-know data, including a particularly valuable group of new methods in the care of cardiovascular patients.

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Sélection

Conseils à une étudiante devant faire un stage à la salle d'Opération.

Les portes de la salle d'opération s'ouvrent devant l'imposante civière, portant son fardeau si mystérieux, si inconnu dans sa vie et dans son âme: le malade.

Pourquoi ses yeux s'ouvrent-ils si grands? Pourquoi cherche-t-il la main amie? Le décor est donc si frappant? Remarque ces grands murs faïencés, dénudés de tout, d'où émerge le simple crucifix dans tout son abandon! Vois cette gigantesque lampe; cette table compliquée de leviers et de pédales; tous ces instruments étalés là, prêts à servir; ce silence lourd de choses qu'il ne comprend pas; cette minutie aseptique; toutes ces personnes vêtues de blanc, les mains gantées, le visage voilé . . . Toi, infirmière avertie, ne comprendras-tu pas le tremblement des lèvres, une larme, la surexcitation ou le calme, le mutisme frappant de ce malade qui voit toutes ces choses s'ordonner et se perfectionner en vue de lui, de sa néphrectomie ou de son appendicectomie. Il est là, attaché à une table, lui un vivant, livré aux chirurgiens. Un moment encore et sa sensibilité sera étouffée par les anesthésiques, son intelligence enténébrée. Il ne pensera plus que par l'intelligence, il ne vivra plus que par la conscience des médecins et des infirmières qui l'entourent. Sauras-tu calmer un peu ses appréhensions?

Oui, si tu sais, dès l'arrivée du patient, le saluer gentiment, lui montrer un intérêt sympathique et le transférer sans heurt sur la table. Parfois, il te dira ses craintes, sa peur; ou bien souvent, il ne soufflera mot. Tu peux, par des paroles adroites, discrètes, déceler assez clairement sur quoi porte sa crainte. Est-ce l'anesthésie? Est-ce l'intervention chirurgicale? Sont-ce les suites de l'opération? Peut-être est-il alarmé par le spectacle de l'outillage ou de l'instrumentation!

Rassure-le par un sourire, un bon mot. Que tes gestes nécessaires à la préparation de l'opération soient faits avec calme et sûreté, surtout sans précipitation. Tu es capable de lui insuffler ces grands sentiments de confiance et de courage parce que tu dois les porter en toi. Surtout, ne va pas paraître indifférente ou trop habituée à ce qui va se passer. Ou bien, ne te laisse pas emporter par la gravité de l'heure en oubliant le patient et en te livrant entièrement aux préparatifs.

Es-tu certaine qu'il a, comme toi, pleinement confiance au chirurgien et à l'anesthésiste? Suggère-le-lui en glissant un éloge discret de ceux-ci: "Votre médecin est tellement compétent et a fait preuve de si grands succès passés. Et vous ne voyez pas l'anesthésiste, toujours aux aguets devant la moindre réaction de votre pouls, votre respiration, votre tension artérielle?

Tous ces bons mots, tous ces sourires rassemblés n'apportent-ils pas un peu de sérénité dans cette âme inquiète?

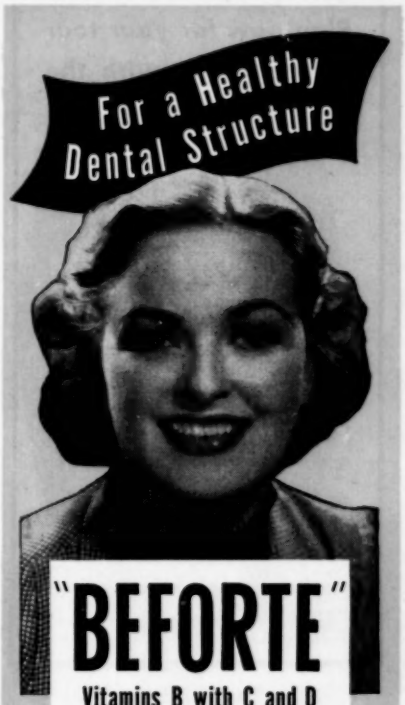
Puis l'immobilisation d'un membre, une certaine position plus ou moins agréable sont parfois nécessaires même avant la perte de conscience du malade. Il est facile pour toi de lui expliquer les motifs de cette immobilisation en prenant bien soin de ne pas découvrir le malade inutilement.

L'opération retarde . . . Laisseras-tu le malade seul avec son imagination vagabonde, errer dans le pays de la peur, des idées noires et des appréhensions? Demeure avec lui. Sache l'entretenir aimablement.

Je disais auparavant de faire l'éloge bien mérité des maîtres de la chirurgie et de l'anesthésie. Oui, bien sûr, mais au-dessus de tout cela, il y a le Maître suprême, divin, qui prend soin des petits oiseaux, qui peut tout et à Qui nous devons tout. Confie-lui la confiance que tu as envers ce grand Dieu d'Amour. Dis-lui comment son coeur est immense, comment Il peut apporter la paix et la résignation. S'il se sent incapable de prier, fais-le pour lui. N'oublie jamais que c'est Lui le grand commandant et que les médecins et infirmières doivent tendre leur volonté, leur esprit pour le plus grand bien du malade.

Un grand chirurgien disait: "Surtout, ne nous pressons pas, nous n'avons pas de temps à perdre."

Marie Lupien, étudiante-infirmière 2ième année. Extrait du Bulletin *Sous le Voile* de l'Ecole Jeanne Mance, Hôtel-Dieu d'Arthabaska. 1956.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Patients overly susceptible to dental diseases frequently have dietary deficiencies. One to three Beforte Tablets daily may prove decidedly beneficial, by supplying abundance of protective factors essential to healthy tissues.
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THE MILDEST BEST-TASTING CIGARETTE

What should a baby be doing at various ages? Emphasizing first of all that there is no absolute criterion and that each baby is a law unto himself, here are some rough standards published in the Journal of the Michigan State Medical Society:

At 1 month he regards you without apparent comprehension.

At 2 months he smiles, maybe at you maybe not.

At 3 months he turns his head.

At 4 months he holds his head up.

At 5 months he rolls over.

At 6 months he transfers objects from hand-to-hand, dropping many.

At 7 months he sits up briefly, but rolls over easily.

At 8 months he creeps — and then look out.

At 9 months he pulls himself up, often pulling things over on him.

At 10 months he cruises, maybe on all fours.

At 11 months he walks with support.

Remember again that your baby has no absolute standards except what he chooses to do. You cannot hurry him or retard him much, no matter what you do.

* * *

Many doctors believe that high blood pressure is more common today because more people do their work at desks or benches and get little exercise. An English study shows that high blood pressure occurs more frequently among bus drivers who are seated all day than among conductors who are constantly running up and down the stairs of London's two-decker buses.

In Memoriam

(Continued from page 808)

died on May 23, 1956 at Monroe, Mich.

* * *

Isobel (Robertson) Portland, who graduated from Toronto General Hospital in 1936 died at Collingwood, Ont. in June, 1956.

* * *

Charlotte Tuck, who graduated from the Mack Training School, St. Catharines General Hospital in 1905, died there on June 13, 1956 in her 82nd year. Miss Tuck had followed the profession she loved for 50 years, having retired only a couple of years ago.

* * *

Irene (Follett) Warwick, who graduated from Toronto General Hospital in 1929, died at Toronto on June 16, 1956. In tribute to her memory, her classmates sent a donation to the Cancer Society.

In the Good Old Days

(*The Canadian Nurse* — October, 1916)

Blessed is the school of nursing that can select from the attending doctors a corps who have the requisite teaching ability to instruct pupil nurses adequately . . . To get a class of pupil nurses to use their brains in the formation of principles and then the application of these principles to new cases is an achievement of far greater value than the acquiring of a few facts . . . The question that the doctor has to decide is how much shall be taught. Too often he wades bravely ahead only to find at examination time his students have been overwhelmed by the great billows of learning . . . It is much better to lay well the foundation of principles, leaving most of the detail to ward instruction. The effect of the doctor's teaching would be much increased if there could be a nurse as ward instructor who would emphasize at the bedside the details in nursing coincident with the subject taken up by the lecturer.

* * *

Why is interest in postgraduate education for nurses developing to such an extent? The first thought is that this is an age of specialization. Different nursing activities, such as public health, call for skills that cannot be provided in the regular course in the hospital . . . The bigger problem is presented by nurses who realize they have been inadequately taught in their own school. When we stop to consider the lack of uniformity in curriculum, the differences in the teaching provided and in the whole tone and atmosphere of some schools, can we wonder that a class of postgraduate students requires skilful handling if they are really to benefit by their additional experience? Moreover, there is often a disturbing question of discipline!

* * *

We have grown in recent years, sometimes to forget that we are nursing the patient and not the disease. Pupil nurses are apt to be most interested in that part of the science of medicine and surgery which least concerns them. The average nurse thinks she is doing much more important work when caring for a postoperative or a fracture patient than when she is caring for a case of disintegrating carcinoma or a paralytic. She changes the dressings on a wound without a murmur but hates to be on a children's

. . . because you must wash your hands frequently

- Helps to restore skin to normal pH after repeated washings.
- Provides frequent and effective antisepsis.
- Combats drying and general skin irritations.

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Pharmaceutical Division, Montreal, P.Q.

ward where she is "always changing babies." Most nurses are much more enthusiastic over what the surgeon does in the operating room than what the dietitian is doing in the kitchen!

* * *

Having all the nursing care given by graduates has been found unsatisfactory because it is difficult to secure a sufficient number, without resorting to the nurse who has somehow or other lost her diploma but always comes from Guy's in London.

For the Man of the Future

If present trends are any indication, the man of the future may be able to have any part of his malfunctioning circulatory system removed and replaced — possibly by synthetics.

At the turn of the century, a German surgeon reported that he had successfully transplanted arterial homografts in dogs but for many years the work advanced no further. Then, in 1949, a method of preserving the viability of grafts until they were needed for transplantation was found. Arterial grafts became something of a practicality. Soon preservation methods were sufficiently developed to permit a Blood Vessel Bank to be opened in New York City. The success of this bank and the proven value of artery transplants in restoring normal blood flow to vital organs in arteriosclerosis, saving limbs after severe accidental injury, replacement of aneurysms and cancerous vessels and substitution for congenitally missing vessels is evident. Now it is hoped that very soon surgeons may be able to operate following a heart attack and either remove the arterial obstruction or take the artery out and replace it. A method is needed to pinpoint the site of obstruction but it is felt that this obstacle will shortly be overcome.

Human arterial grafts are scarce. Even with permanent storage such as is now possible with deep-freezing and freeze-drying, the essential difficulty of procuring grafts remains. Animal studies suggesting that closely woven cloth of some of the synthetic fibres would permit autogenesis of arterial coats of fibrous tissue was a triumph over this difficulty. Recently both British and American workers have reported that plastic implants composed of orlon, dacron, nylon or Vinyon-N have been used successfully in humans. Research is continuing in order to find the most suitable synthetic arterial

grafts. Some of the problems already seem to be solved. By using a braided nylon which can be made wrinkleproof and waterproof, troublesome seams and ragged edges are avoided, the fabric remains permeable to fibroplastic penetration and there is sufficient flexibility to permit grafting across the line of flexion of a joint.

To our Number 1 health problem today, the surgeon is bringing the most concrete hope of cure of any of the specialists. They have raised the question of the year. Can they retread an individual's vascular network, much like you can tires, and save thousands from chronic cardiovascular deaths?

— COMMUNICATIONS ASSOCIATES, INC.

* * *

When I'm getting ready to reason with a man, I spend one third of my time thinking about myself and what I am going to say — and two thirds of my time about him and what he is going to say.

— ABRAHAM LINCOLN

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Burnaby: *Mrs. Mary McIntosh* (Misericordia Hosp., Winnipeg). Calgary: *Treva Tingley* (Victoria Gen. Hosp., Halifax). Edmonton: *Mrs. Jean Howe* (U. of Alta S. of N.). Hamilton: *Frances Lee* (Ham. Gen. Hosp.); *Mary Schaffter* (Gen. Hosp., Birkenhead, Eng.). Lachine: *Monique Gregoire* (Hôpital St. Luc, Quebec). Lincoln-St. Catharines: *Mrs. Luella Springham* (Hackley Hosp., Michigan). London: *Roberta Scanlon* (Victoria Hosp., London). Medicine Hat: *Elizabeth Taylor* (Calgary Gen. Hosp.). Montreal: *Sylvia Evans* (St. Mary's Hosp., Montreal); *Jean Grant* (Charlottetown Hosp.). Ottawa: *Shirley Cameron* (Univ. of Ottawa). Owen Sound: *Kathleen Eby* (Kitchener-Waterloo Hosp.). Peterborough: *Mrs. Anne Campbell* (Royal Infirmary, Edinburgh). Saskatoon: *Jennie Victor* (St. Paul's Hosp., Saskatoon). Toronto: *Elizabeth Burgar* (Toronto Gen. Hosp.); *Phyllis Dawson* (Toronto West. Hosp.); *Lois Dedrick* (Toronto West. Hosp.); *Mrs. Helen Heenery* (McMaster Univ. S. of N.); *Katherine MacDonald* (St. Jos. Hosp., Toronto); *Betty Robbins* (Wellesley Hosp.); *Elaine Shenson* (Univ. of Toronto); *Eileen Warren* (Toronto West. Hosp.); *Mrs. Mary Watson* (U. of T.);

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Transfers — Frances Cook from Truro to Ottawa. *Leolla Brintnell* from York Township to nurse in charge Weston. *Freida Hug* from Toronto to London staff. *Mrs. Julia Gabris* from Sackville to nurse in charge Truro. *Mrs. Dorothy Mathieson* from Victoria to Vancouver staff. *Lorraine Miller* from National Office to nurse in charge Saskatoon. *Mrs. Shirley Simms* from Toronto to North York staff. *Maureen Southcott* from Toronto to Corner Brook staff. *Muriel Stevens* from Toronto to North York staff. *Mrs. Venetta Vyse* from Toronto to Burlington staff. *Janet Zinck* from Toronto to London staff.

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News Notes

BRITISH COLUMBIA

CHILLIWACK

I. Barwell, regional president of the Lower Fraser Valley, presided at the recent regional meeting. Thirty-two members representing Abbotsford, New Westminster and the local chapter were in attendance. Miss Barwell gave a colorful report of the Biennial Convention, praising those responsible for planning enthusiastically. Miss Deacon, a student from the Royal Columbian Hospital reported on "Student's Day." A short program concluded the meeting.

COMOX

Dr. H. A. Mooney addressed a meeting of the district members late in June. His subject, "Golden Staphylococcus Infections" was of vital interest to his listeners since it has produced so many medical and nursing problems. Mrs. Dickie from the Duncan chapter and Mrs. Jones of Victoria gave reports on the annual provincial convention. K. Baillie attended the Biennial Convention in Winnipeg representing the district. The next meeting is to be held in Ladysmith late in October.

PENTICTON

The profession of nursing, and in particular the public health branch, reflected the honor bestowed upon Miss Joan Appleton when she was accorded the Freedom of the City during a recent ceremony. In this way a grateful people acknowledged warmly the devoted services of an outstanding public health nurse, not only in line of duty but in community and church activities as well. Her departure for Chilliwack where she will assume similar responsibilities was cause for sincere regret.

Joan Appleton receives the Freedom of the City

A graduate of St. Thomas Hospital, London Miss Appleton entered the public health field following postgraduate study. During the war years she engaged in civil defence work eventually joining U.N.R.R.A. where her specific duties centred around the care of refugees and displaced persons. In 1947 she joined the B.C. Health Services serving at various times in Ashcroft and Summerland before coming to Penticton in 1950.

QUEBEC

QUEBEC CITY

Jeffrey Hale's Hospital

Dr. D. Gendron gave the address to the graduating class at the alumnae dinner held early this year. Members of the class who received special awards were Mrs. E. Hamel, Board of Governors award for general proficiency and the Dr. J. S. Gregory award in gynecological nursing; J. Richardson, the Margaret Teakle award for bedside nursing; V. Smith, the Women's Auxiliary award for surgical nursing and the alumnae award for showing greatest improvement during the course of training. Each member of the class received a copy of a nurse's quick reference manual as a gift from the medical staff. This year's graduation exercises had special significance for the Richardson family since Janice Richardson was the fifth of five sisters to complete her training at this hospital.

Mrs. J. Green attended the Winnipeg convention as an official delegate from the province.

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  THE ROOSEVELT HOSPITAL, a voluntary, general hospital, offers you this opportunity.

- **Why not enjoy these benefits offered by Roosevelt?**

  BASE SALARY — Begins at $270 per month, without experience. Experience qualifies for higher starting salary.

  INCREMENTS — Start after first 6 months and continue annually.

  BONUSES — $40 for evening and $20 for night duty.

  VACATION — 4 weeks annually.

  HOLIDAYS — 10 annually.

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For further information write to:

DIRECTOR OF NURSING, DEPARTMENT NS, ROOSEVELT HOSPITAL

59th Street West, New York City

GRADUATE COURSE IN EYE, EAR, NOSE AND THROAT NURSING

(Six Month Special Study)

1) Unique learning opportunities planned to meet individual interests.
2) Clinic and operating room experience included.
3) Students from approved schools can be admitted under the Foreign Visitors Exchange Program visas.

For further information apply:

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PRACTICAL NURSES

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SALARY MIN.: $169 — MAX.: $188

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In 1955, Canada's population was 15,573,000 with Ontario and Quebec, in that order, recording the highest figures provincially — 5,183,000 and 4,520,000 respectively. Alberta proved to be the "most marriageable" province with 9.2% of its inhabitants engaging in matrimony. Prince Edward Island showed the lowest marriage rate. Newfoundland recorded the highest percentage of births with Alberta a close second. Quebec, Saskatchewan and Alberta had the lowest death rates of the ten provinces, with equal standing of 7.5%.

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ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
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Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Superintendent of Nurses (1). Salary: $275 per mo. **Graduate Nurses (2).** Salary: $225 per mo. less $40 per mo. room, board & laundry. 28-bed hospital, pleasant surroundings, 5 mi. from U.S. border. 40-hr. wk., 4 wk. vacation after 1 yr. service. 1½ days sick leave per mo., yearly accumulative. Nice nurses' residence. Apply The Grands Forks Community Hospital, Grand Forks, B.C.

Matron (November 1st.) for 27-bed Community Hospital. Salary: $300 per mo. 40-hr. wk. 28 days vacation after 1 yr. service, all statutory holidays paid. Room, board & laundry $40. Good knowledge of X-ray essential. Apply, giving full details to Sec., Slocan Community Hospital, New Denver, B.C.

Superintendent of Nurses for modern 80 bed hospital required immediately. Operating room Supervisor & Registered Nurses for general duty. Good personnel policies and salary for fully qualified nurses. Apply, stating qualifications and experience, to Administrator, Portage Hospital District No. 18, Portage La Prairie, Man.

Superintendent of Nurses for 53-bed hospital. Fully accredited & offering ideal working conditions to a qualified Registered Nurse. Salary: $225 plus full maintenance & apt. in new nurses' residence. Excellent personnel policies. 1 mo. annual vacation. Apply Secretary, Kentville Hospital Assoc., Kentville, Nova Scotia.

Matron for modern 8-bed hospital. Salary: $285 per mo., less $30 for full maintenance. Apply stating experience to Sec.-Treas., Union Hospital, Hodgeville, Saskatchewan.

Matron (1) $230 per mo. General Duty Nurses (2). $200 per mo., with full maintenance for 20-bed hospital. Modern nurses' home. Usual holidays with pay & sick leave, etc. Apply to Matron, Union Hospital, Vanguard, Sask.

Night Supervisor. Salary: $2,760-$3,300 plus cost-of-living bonus approximating $325 per annum. Excellent holiday, sick leave and pension benefits. Apply to Baker Memorial Sanatorium, Calgary, Alberta.

Supervisor of Nursing Service for 50-bed active General Hospital. Salary: $210 plus maintenance with 6 monthly bonuses of 5%. 44-hr. wk. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital Dist. #17, Wainright, Alta.

Supervisor for Pediatrics Dept. with postgraduate course or equivalent. Contract conforms with R.N.A.B.C. personnel practices. Apply Director of Nurses, General Hospital, Chilliwack, B.C.

Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital in progressive town (10,000) in Cariboo Dist. central B.C. 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays. Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

Operating Room Supervisor for 110-bed hospital. Apply, Superintendent, Charlotte County Hospital, St. Stephen, N.B.

Operating Room Supervisor and **General Duty Nurses** for 43-bed General Hospital in friendly resort town. For further information, apply, Superintendent, District Memorial Hospital, Huntsville, Ontario.

Supervisors & Staff Nurses. Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

Hospital Supervisor for 100-bed active General Hospital. Rotating afternoon & night shift. Blue Cross. Statutory holidays. 4 wk. vacation & 2 wk. sick leave with pay after 1 yr. service. Accommodation in residence if desired. Apply stating experience & age to The Director of Nursing, Cottage Hospital, Pembroke, Ont.

Night Supervisor, Assistant Head Nurses & Staff Nurses. Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

An Opportunity for

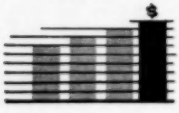
50 NURSES

in Hamilton, Ontario!

The three city-owned hospitals, the General, the Mountain and the Nora-Frances Henderson, have recently undergone an expansion program and are in immediate need of a minimum of 50 Registered Nurses.

Recognized as one of the most modern-equipped hospitals in Canada, the Hamilton General offers the Registered Nurse working and recreational facilities second to none.

Situated in the heart of what has been termed the "Golden Horseshoe", Hamilton is a city practically equidistant to Toronto and Buffalo, big enough to be interesting, yet small enough to be friendly and hospitable to the individual.



The rates of pay to Registered Nurses are the highest in the Province of Ontario. For Registered Nurses who work rotating hours of service, the beginning salary is $53.00 per week. The daily rate is $10.50 for each eight-hour period of duty.

Hours of duty: (a) 8 hour day—42 hours weekly average—rotating service. DAYS: 7 a.m. to 3.30 p.m. or 10 a.m. to 7 p.m.; EVENINGS: 3 p.m. to 11.30 p.m.; NIGHTS: 11.15 p.m. to 7.15 a.m. These schedules include one half hour for each meal and 15 minutes for morning coffee. (b) Two days off three successive weeks and one day off every fourth week. (c) All statutory holidays or compensatory time.

Vacations: Registered Nurses after one year of service receive 3 weeks vacation with pay. It is less than 200 miles to the beautiful Muskoka Lakes District, less than 2 hours to the U.S. border.

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Please send me more information concerning the opening for 50 nurses at your hospital. My address is:

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BRITISH COLUMBIA

Applications are invited for staff & administrative positions for Psychiatric & Tuberculosis units in the Essondale area, which is on the outskirts of Greater Vancouver. These positions have been created through re-organization & expansion of the Department of Nursing.

Positions open:

Supervisors: for 225-bed Psychiatric & Tuberculosis unit. Postgraduate course in supervision or administration & postgraduate course in Psychiatric & Tuberculosis nursing or equivalent experience.
Salary: $260 - $315 per month.

Supervisors: for Psychiatric units. Postgraduate course in supervision & psychiatric nursing or equivalent experience.
Salary: $260 - $315 per month.

Head Nurses: for Medical Surgical Infirmary wards & Tuberculosis wards. Postgraduate course in psychiatric nursing or equivalent experience.
Salary: $255 - $287 per month.

Head Nurses: for Mental Health Centre. Postgraduate course in Psychiatric Nursing or equivalent experience.
Salary: $255 - $287 per month.

Staff Nurses: for Medical Surgical wards & Tuberculosis wards.
Salary: $239 - $271 per month.

Nursing Instructor: for Training School.
Salary: $255 - $287 per month.

40-hour week, statutory holidays, 4 weeks vacation with pay annually. Residence accommodation in modern residence $5.00 per month, cafeteria meal service, 30¢ per meal. Recreational facilities. Applicants must be British Subjects & eligible for registration with Registered Nurses' Association of British Columbia.

Apply to:

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Evening Supervisors, Registered Nurses, Catherine Booth Graduates, Nursing Assistants for 68-bed hospital, 68 mi. from Montreal. Excellent bus & train service. Salaries are in accordance with A.N.P.Q. Full maintenance. 8-hr. duty, rotating shift. 1½ days off per wk. 30 days annual vacation. Sick leave allowance. Blue Cross hospitalization paid by hospital. Apply Supt., Brome-Missisquoi Perkins Hospital, Sweetsburg, Que.

Operating Room Supervisor for 118-bed General Hospital located in a beautiful residential suburb along the North Shore of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Apply Director of Nursing Services, Highland Park Hospital Foundation, Highland Park, Illinois.

Instructor for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Charge Nurse & Supervisory positions at Clearwater Lake Sanatorium, The Pas, Man. Salary range: $220-$260 per mo. depending on qualifications & appointment. Board, room & laundry provided for $39 per mo. in comfortable quarters. Generous vacation, group ins. all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Head Nurse capable of assuming more senior duties later. Good salary & opportunities for the right person. Apply stating age & experience to The Queen Elizabeth Hospital, Toronto, Ont.

Registered Nurses or Non-Registered Nurses if recent graduates (4) for very active 50-bed hospital. Salary: $180-$185 depending on experience, plus complete maintenance & laundering of uniforms. $5.00 increase every 6 mo. to a maximum of $200 & 5% bonus every 6 mo. 88-hr. fortnight with rotating 8-hr. shifts. 10 statutory holidays & after 1 yr. on staff vacation of 21 days & sick time allowance of 14 days. For further information apply Miss M. Jarvis, Matron, Municipal Hospital District #17, Wainright, Alta.

Registered General Duty Nurses (2) for 35-bed hospital. Salary: $185 per mo. plus full maintenance. 4 increments at $5.00 per mo. after each 6 mo. 1 mo. vacation pay, sick leave & hospitalization benefits. If employed for 1 yr. a refund of train fare from any point in Canada given. Apply Miss M. A. MacDonald, Matron, Municipal Hospital, Two Hills, Alberta. Phone 335.

Registered Nurses. Single room residence. $225 per mo. gross. 5 day wk. 20 mi. east of Toronto. Apply Supt. Ajax & Pickering General Hospital, Ajax, Ont.

Registered Nurses. Gross salary for nurses currently registered in Ont. $235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

McKellar General Hospital, Fort William, Ont. requires Registered General Duty Nurses. Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

Registered General Duty Nurses for 35-bed hospital. Salary: $250 less maintenance with increase after 6 mo. & yearly threafter for 3 yrs. Apply Supt., Little Long Lac Hospital, Geraldton, Ontario.

Registered Nurses for General Duty. Initial salary: $200 per mo.; with 6 or more months Psychiatric experience, $210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered General Duty Nurses (3) for new modern 30-bed hospital. New residence. Situated on Georgian Bay. Apply Superintendent of Nurses, General Hospital, Meaford, Ontario.

Registered General Duty Nurses for 200-bed General Hospital. Salary: $220 per mo. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

Registered General Duty Nurses for 200-bed hospital in the Niagara Peninsula. Gross salary: $215, afternoons — $225, nights — $220. Annual increments. 44-hr. wk. 3-wk. vacation per yr., 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

Reg'd. Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES FOR REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, and NURSING ASSISTANTS or PRACTICAL NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic and North-West Territories.

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(1) Public Health Nursing Supervisors: up to $4,620 depending on qualifications and location.

(2) Directors of Nursing in Hospitals: up to $4,620 depending on qualifications and location.

(3) Public Health Staff Nurses: up to $3,600 per year depending on qualifications and location.

(4) Hospital Staff Nurses: up to $3,420 per year depending upon qualifications and location.

(5) Nursing Assistants or Practical Nurses: up to $185 per month depending upon qualifications and location.

• Room and board in hospitals — $30 per month. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-medical and superannuation plans available.

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(1) Regional Superintendent, 4824 Fraser Street, Vancouver 10, B.C.

(2) Regional Superintendent, c/o Charles Camsell Indian Hospital, Edmonton, Alberta.

(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

Registered General Duty Nurses (3) for 45-bed hospital in Southern Sask. Salary: Min. $225. Starting salary according to experience. Full maintenance $30 per mo. 1 mo. vacation, statutory holidays, sick leave. Active town of 3,000 pop. Apply stating experience & when available to Supt., Union Hospital, Assiniboia, Sask.

Registered General Duty Nurses (2) for Municipal Hospital 40 mi. NW of Saskatoon. Excellent bus & train service. Salary range: $225-$255 per mo. Maintenance, $30. Good personnel policies, 1 mo. vacation a yr. Apply E. M. Hillhouse, Sec.-Treas., Municipal Hospital, Borden, Sask.

Registered Nurses (2) for modern 8-bed hospital. Salary: $240 per mo., less $30 full maintenance. For further information apply B.E.L. Magnusson, Sec-Treas., Union Hospital, Hodgeville, Saskatchewan.

Registered Staff Nurses (Immediately) for 220-bed hospital, including new finely equipped wing. Duty assignments in Obstetrical, Medical & Surgical Units. Gross starting salary: $220. Good personnel policies. Paid vacations, sick leave, pension plan. Apply Director of Nursing Union Hospital, Moose Jaw, Sask.

Registered Nurse (1) for 10-bed hospital. Separate residence. Maintenance, $18 per mo. Salary as per schedule plus $5.00 increase per mo. 8-hr. shift. Usual holiday & sick leave. Apply Sec.-Treas., Union Hospital, Rabbit Lake, Saskatchewan.

General Duty Registered or Graduate Nurses (2) for modern 20-bed hospital. Salary: $220 (Graduate), $230 (R.N.). Increment of $5.00 after each 6-mo. service. 1 mo. vacation with pay after 1 yr. service. $30 per mo. maintenance. Separate staff residence. Apply Matron, Riverside Memorial Hospital, Turtleford, Sask.

Registered Nurses. Male & Female. Starting salary: $300 up, plus $10 pm shifts. 40-hr. wk., paid vacation, 10 days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital. Starting salary: $265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

Registered Nurses for 398-bed J.C.A.H. non-sectarian research & teaching hospital with N.L.N. fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Housing available at reasonable rates. Apply Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses (3) immediately for 30-bed hospital. Located in a good town 80 mi. east of Calgary on the CPR main line & the Trans Canada Highway. Salary: $170 per mo. with full maintenance. Increase every 6 mo. 48-hr. wk. 8-hr. rotating shift. Apply by letter or wire for details of our staff plan to Mrs. H. Hislop, Matron, Municipal Hospital, Bassano, Alta.

General Duty Nurses and **Nursing Aides.** Active 700-bed general hospital. From September 1. Good working conditions. Personnel policies upon request. For further particulars apply to Director of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

General Duty Nurse for 17-bed hospital. Starting salary: $200 gross. 1 mo. vacation with pay after 1 yr. service. $5.00 per mo. increase after each 6 mo. service up to 3 increases. Transportation refunded after 6 mo. service. Apply Municipal Hospital, Elnora, Alberta.

General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary $235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Supervisor, starting salary: $225. Must be registered in British Columbia. **Operating Room Nurses,** salary: $230 plus $10 'on call.' & $10 postgraduate. **Charge Nurses,** salary: $245. **General Duty Nurses,** salary $230. Additional salary paid to nurses with 2 yrs. past experience, plus 4 annual increments to $40. 28 days vacation, 10 statutory holidays. 1½ sick days comulative. Room rent at nurses' residence $20 per mo. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

Royal Jubilee Hospital, Victoria, B.C. invites applications for **General Duty Nurses** for permanent positions & vacation relief in 500-bed General Hospital. Salary $227.50-$262.50 5-day, 40-hr. wk. 4-wk vacation. 10 statutory holidays. Pension plan. Attractive employee benefits. Apply, Director of Nursing.

WANTED

Nurses (Bilingual preferred,) Provincial Hospital Campbellton, Prov. of New Brunswick. General Duty Nurses with or without experience in Psychiatric Nursing. Salary commensurate with training & experience:

MINIMUM — $2,760 PER ANNUM

MAXIMUM — $3,078 PER ANNUM

ANNUAL INCREMENT $120

Full civil service benefits after permanent appointment include 3-wk. annual vacation with pay, sick leave credits & superannuation. Comfortable living quarters & full maintenance supplied for $42 per mo.

Apply:

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required immediately for

Munroe Wing (psychiatric)

Regina General Hospital

Salary Range $288 — $350 per mo.

Registered Nurse with professional experience & preferably postgraduate training in Psychiatric Nursing & Nursing Instruction, to be in charge of the training of affiliate student nurses in a 34-bed Psychiatric Ward.

Enquiries & requests for application forms should be sent to:

The Public Service Commission,

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Regina, Saskatchewan

CITY OF WINNIPEG MUNICIPAL HOSPITALS

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REGISTERED NURSES

40-hr. wk. Statutory holidays. Liberal sick time. Pension plan. Holiday allowance.

Accommodation available in nurses' residence.

UNIFORMS LAUNDERED FREE

SALARY MIN.: $215 — MAX.: $248

EVENING DUTY ADDITIONAL $10.

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General Duty Nurses for 148-bed hospital. Salary: $270 per mo. with salary differential for rotating & specialties. 2 wk. vacation with pay after 1 yr. 10 days sick leave each yr. Apply Director of Nursing Service, Saint John's Hospital, Longview, Washington.

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Graduate Nurses (General Staff Positions) for General Hospital. Salary: $239. per mo. as minimum & $277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

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Graduate Nurses for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

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Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

Public Health Nurses for Kent County Board of Health Unit. Minimum salary: $2,840 with annual increases of $150 per yr. for 4 successive years. 38-hr. wk. 3 wks. vacation with pay. All statutory holidays. 2 days a mo. sick leave accumulative to 48 days. Uniforms provided. Ideally located, bordered on the south by Lake Erie & by Lake St. Clair on the west. The city of Chatham being located in the centre of the county with the cities of London, Sarnia & Windsor, Ont. & the city of Detroit, Mich. all within 1 hr. drive making Kent County a most desirable place in which to live & make a living. Apply W. M. Abraham, Sec.-Treas., Kent County Board of Health, 7th St., Chatham, Ont.

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